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Medical Encounter is published four times a year by the American Academy on Communication in Healthcare. ©2014.
ABOUT THE COVER PHOTO

IN THIS ISSUE YOU WILL FIND THE PROCEEDINGS FROM THE 2013 INTERNATIONAL CONFERENCE ON COMMUNICATION IN HEALTHCARE HELD THIS PAST OCTOBER IN MONTREAL. WITH RECORD ATTENDANCE, MORE THAN 400 PROFESSIONALS FROM ACROSS THE GLOBE CAME TOGETHER TO LEARN FROM EACH OTHER THROUGH VARIOUS PLENARY SESSIONS, WORKSHOPS, ABSTRACT PRESENTATIONS, SYMPOSIA, SPECIAL INTEREST GROUPS AND, THE ALWAYS POPULAR POSTER SESSIONS CAPTURED IN THIS ISSUE’S COVER PHOTO. THE EDITORS OF MEDICAL ENCOUNTER HOPE YOU ENJOY THE WORK THAT WAS PRESENTED AT THE 2013 ICCH AND WE THANK EVERYONE WHO HELPED CONTRIBUTE TO THE RICH CONTENT OF THIS EVENT.
Assessing the Psychometric Properties of CollaboRATE: A Three Item Patient Reported Measure of Shared Decision Making Process

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Introduction/objectives: Reviews of shared decision making (SDM) measures have highlighted the need for a brief, generic, reliable and valid patient-reported measure of SDM. In consultation with patients, we developed CollaboRATE, a theoretically derived, three-item measure of SDM process. In the current project we assessed its psychometric properties.

Methods: A socio-demographically representative sample of adults from the USA were recruited from an Internet panel in 2013. Participants completed an online survey where they were randomly allocated to view one of six animated doctor-patient encounters. Three core dimensions of SDM were manipulated in the animations: (i) explanation of the health issue, (ii) elicitation of patient preferences, and (iii) integration of patient preferences into decision-making. Participants then completed CollaboRATE, two other lengthier measures of SDM, SDM-Q-9 and a subscale of the Patient’s Perceived Involvement in Care Scale (PICS), and several other items. A subsample of participants was re-surveyed on a second occasion, between one to two weeks later, where they again viewed one of the six animations and completed CollaboRATE. We assessed the discriminative validity, responsiveness, and test-retest reliability of the measure.

Results: After excluding participants who did not view the entire animation, the final sample comprised 1341 participants. CollaboRATE demonstrated discriminative validity, with a significant increase in CollaboRATE score as the number of core dimensions of SDM present in the animations increased none (Score= 46.0/100, 95%CI 42.4, 49.6) to three (Score=85.8/100, 95%CI 83.2, 88.4). The two other lengthier measures of SDM also demonstrated discriminative validity, using these animations. CollaboRATE also demonstrated excellent responsiveness and test-retest reliability when participants were re-surveyed.

Discussion/implications: The fast and frugal nature of CollaboRATE lends itself to routine clinical use. Further assessment of CollaboRATE in real world settings is required.

Shared Decision Making

Developing CollaboRATE - a Fast and Frugal Patient-reported Measure of the Shared Decision Making Process in the Clinical Encounter

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Introduction: Measuring shared decision making (SDM) from the patient perspective is difficult. Our goal was to develop a measure of SDM process that is fast, frugal, and scalable. Our first step was to focus on generating items and assessing their interpretability among lay people using cognitive interviews.

Methods: We reviewed published models of SDM to identify key dimensions and develop items. We assessed key dimensions by asking patients about the efforts made by providers to perform the following tasks: 1) explain health problems or issues; and 2) elicit patient preferences. We developed preliminary sets of items, for each dimension, with optional sub-phrases. We recruited participants from Dartmouth-Hitchcock Medical Center and conducted cognitive interviews to assess their comprehension and interpretation of items. Interviews were recorded and independently analyzed. A final set of items was piloted with participants to assess face validity and ease of use.

Results: Participants were evenly distributed across three age categories (18-44, 45-64, and over 65). We interviewed 27 participants in the first two rounds. During the interviews, we found participants reflected on challenges of interpretation when asked directly about dimensions. Through further cognitive interviews, we were able to identify items that participants understood and more closely aligned their interpretation with identified key SDM dimensions. The phrase “matters most to you” was an accessible way of discussing “patient preferences”, and the phrase “what to do next” was more understandable than “decision-making”. We found a need for a third item that represented an additional dimension of “preference integration”. We then piloted the instrument with 30 participants immediately following a clinical visit. Participants responded positively to the measure’s brevity and item clarity.

Discussion: We developed a three-item measure of the SDM process ensuring end users’ understanding and interpretations were aligned with identified key dimensions of SDM.
Providing Information Equals Shared Decision Making: the Professionals’ View on Treatment Choice in Early Parkinson’s Disease

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Introduction/objectives: The Dutch guideline on Parkinson’s Disease (PD) regards levodopa and dopamine agonists as equipotent pharmacological therapies in early PD. It recommends that the choice for treatment is based on the individual patients’ characteristics, preferences, and the neurologists’ experience. Patients increasingly express a desire for unbiased, comparative information regarding treatment options, and active involvement in decision making. Considering the preference-sensitivity of the choice, this decision is well equipped for shared decision making (SDM). The aim of this research is to clarify if and how professionals apply SDM for this particular decision in current practice.

Methods: Semi-structured interviews were conducted with 15 neurologists and 7 PD nurse specialists. Saturation was pursued in both groups. Transcripts of the interviews were independently coded by two researchers following the rules of grounded theory.

Results: Neurologists regarded the moment to start with pharmaceutical treatment more suitable for SDM than the choice of treatment. They often offered their patients the freedom to wait with treatment until they considered the disease to interfere with their daily activities. Nonetheless, the neurologists considered not all patients suitable for a postponed patient-directed decision, due to disease severity and the fact that levodopa response can be used to support the diagnosis. With regard to treatment choice, the majority strongly favoured levodopa, and did not regard dopamine agonist as equipotent. Although all neurologists emphasized that they informed their patients about both treatment options, they admitted that this in practice is often not done effectively. Physicians conveyed ambiguous messages when indicating equipo- tent. Physicians made more than ten decisions in most encounters, however few of them were discussed with the patients, and many of them were not suitable for discussion. When treatment discussions were initiated, most of the desired elements of shared decision-making were lacking. Physicians tended to ask for preferences without informing the patients sufficiently, which often seemed to confuse the patient, and resulted in them resisting making a decision. We also observed that physicians conveyed ambiguous messages when a choice was difficult, and in those cases were reluctant to give their own recommendation. Finally, because patients often did not give clear responses or were encouraged to do so, physicians tended to spend much time on persevering communication, sometimes persuasive. We will demonstrate this with examples from two encounters, one with an HIV positive patient who wants to become pregnant, and one with a patient with prostatic symptoms.

Implications: Physicians have not been trained sufficiently for shared decision-making, and seem confused about how and when to do it. Consequently, attempts to involve the patient often fail. This does not inspire the physician to further develop his patient-centered skills and also may leave the patients confused about their participation in treatment decisions.

Including Shared Decision-Making in the Delivery of Clinical Preventive Services: Benefits and Challenges

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Introduction/Objectives: While the role of prevention in reducing illness and disability is well-documented, many patients do not receive optimal preventive care. Simply increasing delivery of preventive services, however, is not the solution. In some cases the possible harms from receiving a clinical preventive service outweigh the potential benefits. In others, the net benefit of a service is unclear. In these situations, open discussions between a clinician and patient about the patient’s individual risk level and goals for care can be particularly important.

Methods: For a project funded by the U.S. Agency for Healthcare Research and Quality, the authors developed a diagram outlining the steps necessary to achieve safe and effective delivery of clinical pre-
ventive services (CPS) in primary care. The framework includes six steps: 1) Patient Access; 2) Identification and Indication; 3) Education and Shared Decision-Making; 4) Delivery of CPS; 5) Delivery of Results; and 6) Maintenance/Follow-up. The authors use this diagram as a framework to assess current knowledge about CPS within primary care. Focusing on Step 3: Education and Shared Decision-Making, we conducted an environmental scan to understand best practices for and challenges to utilizing shared decision-making as part of routine clinical preventive care.

Results: We will present key findings from the scan, including information about clinicians’ attitudes and concerns about involving patients in decisions about preventive care services. Additionally, we will review and discuss current research on best practices for engaging patients and family members in deciding which preventive services they should (and should not) receive.

Discussion/Implications: Shared decision-making can be an important way for clinicians to address with patients issues of unclear net benefit for certain CPS. This discussion can help primary care clinicians better understand the effective use and potential challenges to shared decision-making in routine delivery of clinical preventive services.

Patient Participation

Higher Quality Communication and Relationships are Associated with Improved Patient Engagement in HIV Care

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Introduction: Retention in HIV care is essential to receiving antiretroviral therapy, which dramatically improves morbidity and mortality for patients living with HIV and reduces HIV transmission as a key component of “test-and-treat” prevention strategies. Most prior work on retention in care has focused on patient factors as barriers to appointment adherence, with little attention to the role of patient-provider interactions.

Methods: In an urban, academic HIV clinic, 1,363 patients completed interviews assessing demographics, substance use, and patient ratings of the quality of communication and relationships with their providers on five domains: being treated with dignity and respect, being involved in decisions, being listened to, having information explained, and feeling known as a person. The outcome of appointment adherence was calculated from clinic records as the number of completed appointments divided by the total number of routinely scheduled appointments over one year after the patient interview. We conducted an environmental scan to understand best practices for involving patients in decisions about preventive care services. Additionally, we will review and discuss current research on best practices for engaging patients and family members in deciding which preventive services they should (and should not) receive.

Results: We will present key findings from the scan, including information about clinicians’ attitudes and concerns about involving patients in decisions about preventive care services. Additionally, we will review and discuss current research on best practices for engaging patients and family members in deciding which preventive services they should (and should not) receive.

Discussion/Implications: Shared decision-making can be an important way for clinicians to address with patients issues of unclear net benefit for certain CPS. This discussion can help primary care clinicians better understand the effective use and potential challenges to shared decision-making in routine delivery of clinical preventive services.

The Development of a Rheumatoid Arthritis Medication Summary Guide and Decision Aid for Vulnerable Populations

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Introduction: Communication barriers between patients with rheumatoid arthritis (RA) from vulnerable populations and their clinicians may contribute to differences in knowledge, treatment choices, adherence, and health outcomes. Our objective was to develop a low-literacy RA medication summary guide read prior to an office visit and a decision aid used by patient and clinician in the visit.

Methods: We developed the RA medication guide and decision aid through a process involving collaboration with patients, clinicians, health literacy and decision aid experts, and graphic designers; direct observations of clinical encounters; and literature review. We conducted focus groups with English, Spanish, and Cantonese-speaking patients, and rheumatologists to assess knowledge of and preferences for RA treatment. Qualitative data from focus groups and literature review informed the first iteration of the tools. An RA patient advisory board convened monthly over six sessions to provide feedback on content and design. Insights from these processes informed the creation of prototypes of the tools in parallel that were reviewed and field tested in semi-structured interviews and actual consultations.

Results: The final summary guide content was translated into Spanish and Chinese. Four iterations of the design aid were developed and field-tested before completion. The decision aid organized the data for twelve RA drugs around 5 issues: frequency of administration, time to onset of action, cost, side effects, and contraindications. Clinician and patient responses to materials in the clinics throughout their development have been positive. Results from a clinical trial (n=166; 46% English speakers, 36% Spanish, 18% Chinese) will determine if the tools affect patient knowledge, decisional conflict, and adherence.

Discussion: The process of collaboratively developing an RA medication summary guide and decision aid designed to promote quality, patient-centered care for vulnerable populations with RA resulted in...
Testing Expert Recommendations in CPR Discussions

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Introduction/Objectives: To improve cardiopulmonary resuscitation (CPR) discussions, experts recommend both information-focused and collaborative, value-based approaches. Our objectives were to describe seriously ill patients’ perspectives on how hospital doctors should discuss CPR.

Methods: Qualitative study with twenty seriously ill hospitalized patients on the medical service at a university hospital between August 2011 and August 2012. Two videos were created depicting a hospital doctor discussing CPR with a seriously ill patient. One used an information-focused approach and one a collaborative, value-based approach. During semi-structured interviews, each participant viewed both videos to comment on usefulness and comfort. We conducted a thematic analysis to describe benefits and harms of the two approaches and specific discussion components.

Results: Most patients (n=15 of 20) felt that the discussions depicted in both videos would help them to make a decision about CPR, and most (n=12 of 20) would feel comfortable having a similar discussion with a hospital doctor. Half (n=10) reported no preference between the videos; only 15% (n=3) preferred the collaborative, value-focused video. Participants identified benefits and harms of the two approaches and specific discussion components.

Discussion/Implications: Most participants valued discussing CPR with hospital doctors. From their perspective, expert-endorsed discussion components had the potential both to improve and harm decision-making and the doctor-patient relationship.

The financial burden of cancer care: What are patients’ attitudes toward their costs?

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Background: Patients receiving cancer treatment can experience significant financial distress, but little is known about patients’ cost expectations, willingness to pay, and how shared decision-making should involve costs.

Methods: We surveyed consecutive adult, insured, patients with solid tumors receiving anticancer therapy for ≥1 month, who were being seen at a referral center and 3 oncology clinics. Participants were asked about subjective financial distress (via validated measure), out-of-pocket costs, expected burden, and willingness to pay for their treatment. Medical records were reviewed for disease and treatment data. Logistic regression assessed the relationship between financial distress, expected burden, quality of life (QOL), and willingness to pay (dollar amount).

Results: Among 279 participants (87% response), median age was 60 years (range 27-91), 52% were men, 77% were white, 94% completed high school, and 37% were retired. 78% had incurable cancer. Median income was $60,000/yr. Median out-of-pocket costs were $599/mo (11% of yearly income). 16% reported high/overwhelming financial distress. Overall, 40% reported a higher degree of personal financial burden than what they expected at the start of treatment. In adjusted analysis, higher than expected financial burden was associated with a high/overwhelming financial distress (OR 8.70; 95% CI 3.85-19.66; p=<0.0001), and was not associated with income, employment, race, gender, age, length on treatment, or QOL. Willingness to pay high costs (> $600/mo) was associated with postsecondary education (OR 3.33; 95%CI 1.61-6.93; p=0.0012) and committed relationship status (OR 2.37; 95%CI 1.23-4.56; p=0.0098). Those experiencing higher than expected burden had lower willingness to pay high costs (OR 0.44; 95%CI 0.24-0.79; p=0.006).

Conclusions: Many insured patients faced out-of-pocket cancer treatment-related costs greater than what they expected. As unexpected costs are associated with financial distress and willingness to pay for care, shared treatment decision-making and communication should involve discussion of costs from the outset.
The Negative Effect of Premature Reassurance in Encouraging Children to Receive a Preventive Health Care Measure

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Introduction: Childsmile is a Scottish Government prevention programme to reduce dental decay among children. The BEHAVE study aim was to understand how staff encouraged naïve children to receive a new intervention. About 1 in 12 children refuse this intervention. This presentation will give an outline on how we analysed a large data set of video recordings of children receiving this national programme intervention (fluoride varnish). Some interesting nurse behaviours are associated with refusals. We are interested in examining the link between sequences of nurse behaviour and negative responses by children. We will present a variety of models, derived from theoretical principles, that were suitable for testing.

Methods: 60 children (30 refusers, 30 non-refusers) were videoed in a community setting. These 3-5 year old children were offered the fluoride varnish. The behaviour of the children and nurses was coded using a validated system: SABICS; see PEC 2012, Vol 88(2), 268-276. The models to be tested include detailed time-stamped information that is lacking in previous research of this type. Some interesting nurse behaviours are associated with refusals. We are interested in examining the link between sequences of nurse behaviour and negative responses by children. We will present a variety of models, derived from theoretical principles, that were suitable for testing.

Results: Staff behaviours varied for each child from 1 to 127 events. There were over 1800 rows of data included in the analysis. To produce robust standard errors a number of cases were removed (n=5) where less than 4 staff behaviours were coded in the interaction. Two major families of sequential modelling were applied, namely simple and cumulative. The early use of reassurance in the interaction predicted less non-verbal agreement in the child (p<.001). This effect was reflected in addition with children who refused or not. These effects were independent of the two types of sequential model fitted.

Conclusion: Premature reassurance appears to reduce positive cooperative behaviour in naïve children towards a preventative oral health care intervention.

Trust

Perception of provider communication among patients with diabetes: potential influences of medical mistrust and depression in a public health setting

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Objectives: In diabetes care, patient-provider communication is modifiable and may be linked to patient outcomes. Less is known about the association between medical mistrust, depression, and patient’s perception of communication quality. The aim of this analysis is to examine the relationship between these factors within the context of a low-literacy/numeracy-focused intervention to improve diabetes care and outcomes.

Methods: Health care professionals from 10 health department clinics received training in effective diabetes-related communication or exposure to standard diabetes education (NDEP) in a randomized trial. Baseline patient assessments included: demographics, health communication (IPC-18), health literacy (STOFLA), depression (CES-D), medical mistrust (MMI), and glycemic control (A1C). Multivariable linear regression models were used to evaluate the association between the MMI, CES-D, A1C and the IPC-18. All models were adjusted for age, race, gender, income, insulin use, years since diagnosis, literacy, and intervention status.

Results: From July 2011 to November 2012, 349 patients were enrolled: mean age was 49.9 ± 9.5, 61% were female, and three racial/ethnic groups were primarily represented (White 63%; Black 17%; Hispanic 20%). Most were uninsured (91%) with low income (83% <$20k annually), and mean A1C was 9.6 ± 2.1. Clinically significant symptoms of depression (18.9 ± 12.9) and high levels of medical mistrust (2.5 ± .49) were observed across all racial/ethnic groups. In adjusted analyses, MMI was significantly associated with eliciting concerns (EC) [B = -.17 (-.44,-.09), p=.004], explaining results (ER) [B = -.14 (-.42,-.04), p=.02], and deciding together (DT) [B = -.17 (-.39,-.11), p=.005]. Neither medical mistrust nor depression was independently associated with glycemic control.

Discussion: Among diabetes patients seeking care in a public health setting, medical mistrust was significantly associated with reports of lower quality of provider communication. Additional research is needed to explore the impact of mistrust and communication quality on diabetes control for vulnerable patient groups.

Previous negative health care experiences and institutional trust in three racial/ethnic groups in the US

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Introduction/Objectives: There are known differences in health care trust among racial/ethnic groups in the US, and they are related to disparities in health. Little is known about the factors that contribute to these disparities. Our objective was to explore if differences across the 3 largest racial/ethnic groups in the US can be explained by health care access, usage and previous negative health care experiences.

Methods: We studied a convenience sample of 567 adults surveyed in Chicago-area grocery stores who self-identified as African American, Mexican-Hispanic, or white. We measured institutional trust using a 36-item Health Related Trust Measure and dichotomized responses into “high” and “low” trust. We examined if institutional trust varied across racial/ethnic groups with chi squared tests and then used multivariable logistic regression to investigate how race/ethnicity, age,
Results: In an adjusted analysis, race/ethnicity was significantly associated with institutional trust (p<0.001); 61% of whites, 47% of African Americans, and 39% of Mexican-Hispanics were in the high trust group. In the fully adjusted model, African Americans and Mexican-Hispanics had greater odds of reporting low trust compared to whites (OR 1.90; 95%CI, 1.13-3.17; and OR 2.34; 95%CI, 1.43-3.81, respectively). In adjusted analyses, reporting a previous negative health care experience in the last 5 years was the only other significant predictor of having low trust (OR 2.84 and 95%CI, 1.83-4.41).

Discussion/Implications: Our study suggests that differences in institutional trust vary by race/ethnicity and that improving health care experiences, especially for racial/ethnic minority groups could improve institutional trust and decrease disparities in these populations.

An examination of patients’ trust in physician before and after two outpatient visits in a prospective cohort of heart failure patients

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Background: Patients’ trust in physician is an important aspect of successful patient-physician relationships. Yet few studies have examined the development of trust in physician over time.

Methods: Patients age 18 or older were treated for an exacerbation of heart failure at one of two Veterans Affairs hospitals. Demographic and visit data were collected at pre- and post-visit interviews using self-report questionnaires during a 6 month follow-up period. Measures included patients rating of trust in their physician (5 item scale, scored on a range from 1 to 100 points) with higher values representing higher trust in physician. Patients rated physicians’ supportiveness and informativeness and rated their own self-efficacy to communicate and perceived discrimination in health care. A total of 150 subjects with 523 measurements of trust in physician were used to examine change in trust over time and to examine the association of trust with demographic and visit variables. We used bivariate mixed-effect models to account for repeated measures of trust. We modeled change in trust over time with a multivariable mixed-effects model to account for repeated measures and control for potential covariates.

Results: Patient reported mean (SD) trust scores were 81.1 (17.7), 87.8 (16.5), 84.0 (18.0), and 88.1 (17.8) points before, and after visit 1, and before, and after visit 2, respectively. Patients’ mean age was 60 (8.8) years, 65% of patients were black, 41% reported income above $20,000, 65% were from the southern study site, and 59% saw the same doctor at the two study visits. The mean (SD) time between the two visits was 108 (67.2) days. Race was not significantly associated with trust (P=0.15). Patients who reported that the doctor was more supportive and was more informative reported higher trust (0.6 and 0.5 points, p<.0001, respectively). Patients who reported higher self-efficacy to communicate and a belief in alternative medicine had 0.4 points (P<.0001) and 0.1 points (P=0.002) higher doctor trust, respectively.

To control for multiple confounders and to model change in trust over time, data were analyzed with a mixed-effects linear model. Pre-visit trust was not statistically different between visits (P=0.15). Similarly, post-visit trust did not differ between visits (P=0.90). Compared to pre-visit trust, post-visit trust was 5.46 points (P<.0001) higher across two visits, after adjusting for other covariates. Post-visit trust was not lower for patients who were black, reported low income, discrimination, or changed physicians between the two visits (P>0.05). Post-visit trust was higher for patients rating physicians as more supportive, holistic, and informative (P<.01).

Conclusion: Patients reported trust in physician improved from before to after a visit, but the gain in trust was not maintained when measured prior to the next visit. Trust was not associated with race or perceived discrimination in health care, but was associated with patients’ ratings of doctors’ supportiveness and informativeness. This study was small and was limited to patients who kept follow-up visits and results may not generalize to all patients. Longer durations of observation may be needed to examine the development and persistence of trust in physician over time; nonetheless, our results suggest that physicians can earn trust at each visit.

Attachment style and locus of control determine patients’ trust in their oncologist

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Background: Trust in oncologist communication and trust in the observed oncologist. Participants’ self-reported attachment style (i.e., avoidant and anxious), health locus of control and trust in their own treating oncologist were assessed.

Methods: In a scripted video-vignettes study, oncologist communication was systematically varied with respect to their competence, honesty and caring, using a 2x2x2 factorial design. Cancer patients (n=345) viewed the videos and reported their trust in the observed oncologist. Participants’ self-reported attachment style (i.e., avoidant and anxious), health locus of control and trust in their own treating oncologist were assessed.

Results: Higher attachment avoidance was associated with lower trust in the observed oncologist (p < .05). Attachment anxiety was unrelated to trust. Participants with a strong external health locus of control reported more trust in the observed oncologist (p < .001). The positive effect of oncologist caring behavior and honest information-giving on trust was weaker for avoidantly than for securely attached
Discussion: These results indicate that patients’ attachment avoidance may hamper their trust in an observed oncologist, and in their own oncologist to an even stronger degree. We confirmed observational findings that patients with an external health locus of control are more trusting of their oncologist than those with an internal locus of control. Finally, as expected, oncologist communication impacts on trust differently, based on patients’ attachment styles. This finding underlines the importance of oncologists tailoring their communication to individual patients.

Health Literacy

Effective communication for people with limited health literacy

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Introduction: Although health-related information is widely available, some people fail to understand health materials due to insufficient health literacy. This causes increased risks; people with limited health literacy are, for example, less likely to use preventive health services such as cancer screening. Research has shown that the use of illustrations and improved text readability may enhance message processing and comprehension among people with limited health literacy. However, the mechanism underlying these findings as well as the effect of a combination of the two strategies are both still unknown.

Methods: This study investigates the effects of a combination of illustrations and message complexity on information recall, using a 2 (limited vs. adequate health literacy) x 2 (illustrated message vs. non-illustrated message) x 2 (non-complex message vs. complex message) between subjects design. Health literacy was measured with the Dutch SAHL. The experimental messages addressed the benefits of colorectal cancer screening. A national screening program for colorectal cancer will start in the Netherlands in September 2013. Participants (N = 559) were aged between 55 and 87.

Results: The first key finding was that people with limited health literacy recalled less information than people with adequate health literacy. Second, non-complex messages, which were characterized by concrete words and good readability, positively affected information recall for both health literacy groups. Third, results showed an interesting three-way interaction; adding illustrations to the texts only improved recall scores for complex messages (not for non-complex messages), and only for participants with limited health literacy.

Implications: The findings indicate that reducing the complexity of health messages is the most effective strategy to improve information recall among people with limited health literacy. Furthermore, illustrations can be especially useful to improve recall of messages of which the complexity cannot be further reduced.

Health Literacy Listening Skill and Functions of Patient Questions Following Cancer Risk Reduction Counseling

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Introduction/objectives: Patient engagement is manifest in their question-asking. High literacy patients ask providers more questions. However little is known about the functions of questions asked by highly or low HLs. This study compares the variety of questions generated by high and low HL patients in simulated cancer protection interactions.

Methods: 435 diverse health plan members listened to three cancer-related patient-provider interactions discussing (a) prophylactic tamoxifen for a patient at high risk of breast cancer, (b) PSA testing for prostate cancer, and (c) colorectal cancer screening. Participants were asked to articulate all the questions they would ask the provider in each vignette. Participants were administered the Cancer Message Literacy Test-Listening (CMLT-L). The CMLT-L was selected to specifically focus on cancer information and because listening HL is especially linked to patient-provider interaction. Participant questions were coded into (1) assessing risk/benefit, (2) clarifying medical procedures, (3) personalizing information, (4) seeking new information, (5) establishing locus of decision-making, and (6) establishing provider expertise. A 6 (question function, the repeated measure) x 2 (CMLT-L median split) ANOVA was performed. The dependent variable reflected variety of question2 in each function.

Results: Question function interacted with HL. Higher HLs predominated in variety of questions that assess risk/benefit. However lower HLs predominated in variety of questions to personalize information. This pattern persisted even when education was covaried. For both high and low HLs, question variety was greatest for risk/benefit and for treatment procedure questions.

Discussion/implications: Since higher HLs ask a large variety of questions assessing risks and benefits of treatment options, HL training interventions to increase patient question-asking should emphasize that particular function. The finding that lower HLs produce a large variety of questions applying cancer information to their personal cases suggests that providers should frame information to low HLs in those individualized terms, rather than as generalizations.
Patient Activation, Not Health Literacy, Determines Bowel Preparation Quality for Colonoscopy

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Background: Colonoscopy, an effective screening modality for colorectal cancer, requires good bowel preparation quality for polyp detection. Optimal colonoscopy preparation requires patients to adhere to written instructions and be activated to complete the task. Health literacy and patient activation are associated with multiple health outcomes in chronic disease, but have not been extensively studied in colonoscopy. We examined the association between health literacy, patient activation and bowel preparation quality.

Methods: We analyzed outpatient colonoscopies among a sample of 462 adults ages 55-74 who previously completed extensive neurocognitive assessments as part of a prospective study - Health Literacy and Cognitive Function in Older Adults (LitCog). Structured interviews were conducted to obtain demographics, health literacy measured by the Test of Functional Health Literacy in Adults (TOFHLA), and patient activation measured by the Patient Activation Measure short form. We collected clinical information on bowel preparation quality and other colonoscopy quality indicators.

Results: The mean age of participants was 62 (SD 6). One third (N=134) had suboptimal bowel preparation quality; 15% (N=62) and 17% (N=72) had fair and poor quality, respectively. Limited health literacy was associated with lower education (p<0.001), diabetes (p<0.001), and a higher number of chronic conditions (p<0.001), but not colonoscopy preparation quality. No baseline characteristics were associated with patient activation. In multivariable analysis, after adjusting for demographics and clinical characteristics, diabetes (OR 2.93, 95% CI 1.35-6.36) and patient activation (OR 2.07, 95% CI 1.27-3.40) were independent predictors of suboptimal bowel preparation quality, while limited health literacy was not (OR 0.76, 95% CI 0.44, 1.31).

Conclusions: This was the first study to investigate the relationship between health literacy, patient activation and colonoscopy preparation quality. Patient activation was an independent predictor of bowel preparation quality. Interventions to improve colonoscopy preparation quality should consider the importance of patient activation within their design.

Amelioration of oral literacy deficits in prenatal care: results from a randomized trial

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Introduction/Objectives: Engagement in the medical dialogue is especially challenging for patients with restricted literacy. The objectives of this study were to develop and evaluate an interactive, computer-based intervention designed to change visit communication of pregnant women with restricted literacy.

Methods: We conducted a randomized comparative effectiveness trial contrasting an interactive computerized communication intervention that incorporated key social learning theory elements with a face-to-face review of relevant sections of a prenatal education book targeting low literate women. Visits were recorded and coded using the RIAS and participants completed post-visit assessments.

Results: 84 patients cared for by 23 obstetrical residents and 2 nurse practitioners were randomized to two study groups. Patients averaged 24 years of age (range 16 to 44), were predominantly African American (84%), on public assistance (92%) and poorly educated (39% with < 12 years; 38% High School or GED diploma). Visit length did not differ between groups, but there were significant dialogue differences favoring the computer group in patient centeredness, lowered clinician verbal dominance, greater patient disclosure of biomedical and psychosocial/lifestyle information, expression of concerns, and articulation of visit agenda. While clinician communication was not targeted, providers asked more psychosocial questions and were more verbally facilitative but less informative and reassuring with computer group patients. In post visit ratings, clinicians reported learning more about computer group patients and rated them as showing more signs of depression and poorer physical health. Patients in the computer group reported lower visit satisfaction.

Implications: The computer based intervention changed the medical dialogue in positive and targeted ways compared to an in person intervention but was also associated with lower patient satisfaction. While clinically important for effective patient management, disclosure and discussion of concerns with one’s provider can be distressing, may elicit negative feelings and perhaps raise expectations that contribute to lowered satisfaction
Using the Health Literacy Pathway Model to develop the ‘EMPOWER-MS’ self-management programme for people with advanced multiple sclerosis: theoretical review and mapping, qualitative needs analysis with stakeholders and intervention modelling

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Introduction: Health literacy provides a framework to design more effective self-management programmes tailored to individuals’ needs, competence and confidence in managing their condition. This could be highly valuable for people with a range of long-term conditions and Multiple Sclerosis in particular where interventions to date have generally had small effects.

Objective: We sought to use the Health Literacy Pathway Model’s five stages (which view health literacy as both a process and an outcome) and qualitative work with patients with MS, carers and clinicians, to develop a comprehensive self-management intervention for people with advanced Multiple Sclerosis - the ‘EMPOWER-MS’ programme.

Method: Theoretical review; empirical needs analysis with stakeholders; mapping existing interventions to Health Literacy components; synthesis and modelling of EMPOWER-MS self-management programme; content validation with stakeholders.

Results: The programme comprises 8 sessions (7 weekly sessions, and a final follow-up 3 months later), each session aiming to develop specific aspects of someone’s health literacy (knowledge, skills, communication etc) and/or to enhance their self-efficacy regarding fatigue management, pain control, depression, exercise and relaxation techniques; adjusting to changing illness trajectory including muscle, continence and cognitive problems; developing problem-solving and decision-making skills to apply in everyday life; using complementary therapies; sustain improvements in overall health.

The programme incorporates interactive discussions with group-based activities, facilitated by a Nurse Specialist or Therapist and a lay-member with MS. The face-to-face programme is complemented by workbooks with weekly tasks to promote application of newly gained skills to participants’ personal situations and facilitate habit formation of healthy behaviour, and an online forum for peer support, advice and information resources.

Discussion/ Implications: The theoretically-based EMPOWER-MS intervention represents a significant potential advance in current service provision to enhance self-management in persons with advanced MS and now requires mixed-methods feasibility and pilot evaluation, and full trial evaluation if pilot findings are favourable.

Keywords: Multiple Sclerosis; long term conditions; health literacy; self-management; self-care; qualitative.

Cancer Communication

Patient Self-Report of Colorectal Cancer Screening Discussions with Primary Care Physicians: What Screening Options are Being Discussed?

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Introduction: Research has shown the importance of clinician discussion and recommendation of colorectal cancer (CRC) screening. Recent research indicates that providing patients a choice of screening options may increase CRC screening completion, particularly among racial and ethnic minorities. We assessed the frequency of CRC screening discussion, and which screening tests were discussed during non-acute general internal medicine (GIM) visits with average risk, 50-75 year-old Hispanic/Latino (H/L) and Non-Hispanic Black patients.

Methods: Data were extracted from an ongoing study to promote CRC screening among patients seen in primary care clinics in a large, urban area. English and Spanish-speaking patients who were not up to date with CRC screening were administered a survey before and immediately after their physician visit. Descriptive statistics identified if discussion of screening occurred during the visit and if so, what type of test(s) were discussed.

Results: Among 528 patients, 43.9% identified as H/L; mean age 57.8 (SD=6.1); 72.9% were female; and 30.1% were uninsured. Post visit, 48.9% reported that their physician discussed CRC screening. Of those, 78.7% reported discussion of specific CRC screening tests. Referring specific tests discussed, 25.1% reported colonoscopy; 83.7% reported colonoscopy; 0.5% reported flexible sigmoidoscopy; 3.0% could not recall the specific tests discussed. Of 158 participants who reported discussions of colonoscopy, only 14.1% reported also discussing stool tests.

Discussion: During the majority of visits when CRC screening was discussed, only one screening option was presented and most often that option was colonoscopy. Besides increasing the frequency of discussion of CRC screening within non-acute GIM visits, clinicians should consider offering patients a choice of CRC screening modalities. Increased communication regarding screening options may serve to increase CRC screening completion, particularly among racial and ethnic minority, uninsured or low-income patients.

Keywords: Colorectal cancer, racial and ethnic minorities, physician communication of preventive care
How chemotherapy patients and non-patients perceive the side effects of chemotherapy: A comparative study

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Introduction: Understanding patients’ perceptions of treatment consequences is essential to provide optimal patient-provider communication. According to the common-sense model of illness representation, patients actively form illness representations in coping with their illness. The perception of treatment consequences is one dimension of the illness representation. The side effects of a chemotherapy treatment can be perceived as so severe and so distressing that patients may delay or even stop treatment. This study gives insight into perceptions of chemotherapy side effects, into differences in these perceptions between chemotherapy patients and non-chemotherapy patients (i.e., potential new patients), and into factors that influence these perceptions.

Method: An online survey (n=2890) was carried out where respondents were assigned to three groups: (1) (former) chemotherapy patients (n=999), (2) non-chemotherapy patients that are highly involved with a significant other that has been treated with chemotherapy (n=729), and (3) non-chemotherapy patients that are not (highly) involved with a significant other that has been treated with chemotherapy (n=1162).

Results: Nine out of the fifteen measured side effects were perceived as significantly less bothersome by chemotherapy patients than non-chemotherapy patients would expect. On the other hand, four side effects (‘fatigue’, ‘changes in sexuality’, ‘hand-foot syndrome’, and ‘effects on fertility’) were perceived as significantly more bothersome by chemotherapy patients. A significant relationship between cancer and chemotherapy beliefs on the one hand and perceived/expected side effects on the other hand was found. More negative beliefs were associated with more negative perceptions/expectations of side effects in both chemotherapy patients and non-chemotherapy patients.

Discussion/implications: The results of this study can be used to improve patient education. Healthcare providers should tailor their communication differently to first time chemotherapy patients and patients that have been treated with chemotherapy before. Providing realistic expectations about cancer and chemotherapy seem to be important factors in patient education about chemotherapy.

Perspectives on family building among straight and sexual minority patients after cancer

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Background: Fertility concerns have been shown to be particularly important to young female cancer survivors (<40 at diagnosis). However, the topic has been conducted primarily with straight populations and often excludes men. This study focuses on how heterosexual and sexual minority men and women think about potential fertility loss and family building.

Methods: Participants (n=49, Straight: men (n=10) women (n=19), Sexual minority: men (n=6) women (n=14); age range 16-40), were recruited through social media, completed one telephone interview and were compensated with a gift card. Thematic analysis was conducted by two researchers independently and discussed with a third to reach consensus.

Results: Straight women (n=11), straight men (n=9) and bisexual women who partnered primarily with men (n=4) stated that, prior to diagnosis, they thought about parenthood in a “traditional way” – heterosexual marriage and having biological children. Many women who partner with women (lesbian (n=6) and bisexual (n=2)) and gay men (n=2) reported they had more inclusive and flexible ideas about parenthood. Straight men and women endorsed adoption primarily if they had a personal or family history of adoption.

Some straight women, but none of the sexual minority women, men mentioned conflict with their partners about how to bring children into the family. Members of all groups felt a sense of loss learning about reduced fertility. However, only two sexual minority women and four straight men mentioned they were unsatisfied with the information they were given about potential fertility loss, whereas half of the straight women mentioned this.

Conclusions: Sexual minority cancer survivors report different family building goals and less distress when faced with cancer-related infertility compared to straight women. Focusing on multiple means of family building rather than infertility post-cancer may lessen distress for those who cannot have biological children.
The Development, Implementation and Evaluation of a Communication Skills Training Program for Practicing Oncology Nurses

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Introduction: Inpatient oncology nurses face challenging situations communicating with patients and families related to the diagnosis and treatment of cancer. There are limited programs for oncology nurses to enhance their therapeutic communication skill set. A major comprehensive cancer center developed a communication training program with the goal of providing inpatient oncology nurses the communication skills to respond to daily challenges with inpatient cancer patients and their families.

Methods: A 3-module (empathic communication, end-of-life communication, and challenging interactions with families) day-long curriculum was developed following an established model of communication skills training. Each module is delivered with a brief didactic session demonstrating tailored communication skills, followed by 90 minutes of facilitator-led small group role play sessions with standardized patients (SPs). Small groups are co-led by a nurse facilitator and a communication facilitator, and provide a platform for nurses to practice communication skills. Participants complete SP assessments before and after training for skill uptake assessment. Participants also complete self-report surveys after each module and six months post-training. Since its implementation in 2011, 174 nurses have completed the communication training program and corresponding assessments.

Results: Paired samples t-test indicated a significant difference, t(506)=-22.62, p<.001 between pre-training (M=3.28, SD=.86) and post-training (M=4.05, SD=.66) self-efficacy ratings. In particular, self-efficacy improved significantly for each of the modules: empathy, t(170)=-13.32, p<.001; end-of-life, t(169)=-15.67, p<.001; and challenging interactions with families, t(165)=-11.02, p<.001. Additionally, significant improvements in SP ratings were evident for 8 out of 14 checklist items including asking open questions, validating emotions, normalizing emotions, and reviewing next steps.

Implications: The findings indicate that a 3-module communication training program is effective in changing nurses’ communication self-efficacy and SP-rated communication behavior. Further work will code communication skills in SP interactions and examine long-term effects of training.

Information seeking and avoidance throughout the cancer patient journey: A meta-ethnography of qualitative evidence

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Introduction: Although the vast majority of cancer patients want to have as much information as possible regarding their disease and actively seek such information from a wide range of sources, there is a considerable proportion of patients who prefer not to have further information. We conducted a synthesis of published qualitative research to provide insight into patients’ motivations for cancer information seeking and avoidance.

Methods: We searched five electronic databases covering a wide range of disciplinary areas: Medline, CINAHL, PsycINFO, Communication & Mass Media Complete, and Sociological Abstracts. We complemented this process by reviewing reference lists of relevant articles and searching in Google Scholar. We independently assessed the quality of selected studies and used the technique of meta-ethnography to synthesize available qualitative findings.

Results: Eighteen articles that reported the information seeking experiences of 650 patients diagnosed with more than 20 different types of cancer were included. The synthesis identified five second-order constructs (experience of diagnosis; sense of control; trust in medical expertise; hope and fear; and normality), which were grouped into four interrelated themes. Our reading of emerging, reciprocal themes pointed towards the exploration of “mediating” factors which were not overt in individual studies and could play a role in individuals’ motivations to engage in cancer information seeking. This resulted to the identification of four third-order constructs: patient characteristics; disease characteristics; characteristics of incoming information; and context of cancer care.

Discussion: This meta-ethnography provides systematic evidence on the fluid boundaries existing between information seeking and avoidance throughout the cancer patient journey, while offering a theoretical framework of key factors influencing individual’s willingness and potential to effectively undertake the role of “informed patient”.

Professional Health

The problem with “other doctors”; Borman-nian fantasy theme analysis of seated physician rounds

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Introduction: Symbolic Convergence Theory (SCT) is a general communication theory that was introduced by Earnest Bormann in 1976. SCT assumes that humans are inherent storytellers that co-create reality through discourse and has the ability to recruit, convert, or
sustain a group conscious. Within the theory, is a tool called fantasy theme analysis, which uses a dramatistic lens, allows researchers to extract the unique symbolic reality of a communication community.

**Methods:** In 2012 I conducted a participant observation study for 23 days at the University of New Mexico Hospital (UNM) in their general pediatrics unit (GPU) in order to discover the unique symbolic realities that physicians shared with one another about working with pediatric patients and their families.

**Results:** What I discovered was the villainous character of the “other doctor” which appeared in nearly every conversation. The dramatic persona of “other doctor” represented the source of much of the physician’s daily work because they had to repair damage to patients by incompetent doctors. There was also an emphasis for medical students and residents to be cautious not to become the “other doctor” through saying or doing anything stupid. Also, “other doctor” was not exclusive to M.D.’s but could include other healthcare workers or entire medical systems.

**Discussion:** This study provides important insight into the group consciousness that physicians have about themselves and other healthcare professionals.

Caring for Patients in Critical incidents: Impact on Paramedics’ professional and personal life experiences

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**Introduction/objectives:** Paramedics’ work frequently involves dealing with critical incidents (CI). This encounter might trigger emotional, cognitive and behavioral responses in paramedics, presenting them with a variety of difficulties on their way to, during and after the event. This study aimed to examine paramedics’ experiences when encountering CI. The main research questions were: (1) What do paramedics experience during CI? (1a) What impact do such encounters have on paramedics’ work and on their personal lives? (1b) How do paramedics cope with the feelings and thoughts resulting from such encounters?

**Methods:** We conducted a qualitative research. Participants were 15 Israeli paramedics who worked in Intensive Care Ambulances, in a large emergency service organization, and were selected using purposeful sampling. Data were gathered through in-depth semi-structured interviews, which were transcribed and content analyzed.

**Results:** Two major themes were revealed: (1) Between Detachment and Connection; (2) Between Control of the Situation and Lack of Control.

**Discussion/implications:** Paramedics who connected with their feelings regarding the patient and/or the family, as well as those who experienced lack of control, experienced difficult, complex and negative emotions, which challenged their professional competence and personal worldview. Paramedics, who experienced cognitive and functional control of the situation, reported a positive and empowering experience, and were able to maintain their professional and personal identity, strengthening their professional self-confidence. They used a variety of personal and professional strategies to restore their professional self-confidence and sense of control over the situation, thereby minimizing their emotional distress. These findings expand the knowledge about professionals’ experiences of encounters with patients and families in CI, thus contributing to the understanding of professionals’ coping strategies in such situations. Knowledge generated from this study may assist in the development of training programs to enhance professional and organizational coping strategies, which should improve the quality of patient care.

Promoting Professionalism Through Reflective Practice and Identity Formation

**Authors:** Paul Haidet, The Pennsylvania State University College of Medicine Mary Lynn Fecile Susan Glod Patricia Gordon Deborah Kees-Folts David Richard Chengwu Yang

**Introduction:** Research suggests that students become less patient-centered in response to the organizational culture, or “hidden curriculum,” of medical school. Students often feel compelled to make compromises when they experience tension between competing values in clinical teaching environments. To address this, we implemented a modular, longitudinal professionalism curriculum for third-year medical students.

**Instructional Methods:** We aimed to increase capacity for reflective practice as a remedy for the deleterious effects of the hidden curriculum. We were guided by a theoretical model (Figure 1) that considers the tension created when a student encounters behaviors and attitudes that differ from what they consider to be ideal.

![Figure 1](image)

Our reflective activities focus on helping students to: a) define and articulate their own ideals regarding medical practice, b) understand forces in medical care that may either pull them away from or help them to sustain their own ideals, and c) make deliberate choices when they feel pressure to behave in less than ideal ways. We designed five one-hour sessions (Figure 2) occurring during an “island” session at the beginning of the third year and the pediatrics, medicine, primary care, and family medicine clerkships. Each session begins with a 15-minute writing prompt, followed by 45 minutes of group discussion. We built a web-based system for students to archive their writings, and encouraged students to use these writings to frame residency application personal statements.
Evaluation: Our first cohort is currently completing the curriculum. We are collecting a combination of qualitative and quantitative data evaluating student reflective capacity, and attitudes toward professional ideals, creativity, and mindfulness.

Discussion: Our curriculum represents an attempt to create reflection, guided by a theoretical model, and intended to reduce the acculturating effects of the hidden curriculum. We will present preliminary process and outcome data from these efforts.

Physician personal-life satisfaction system as a predictor of physician stress

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Objective: The purpose of the research was to examine physician satisfaction and physician stress. It was hypothesized that systems of physicians’ satisfaction would be a significant predictor of their stress.

Method: Survey packets were mailed in three waves to the 1,840 physicians on the active medical staff list of a seven-hospital not-for-profit healthcare system in the Southeastern United States. A total of 696 physicians returned survey packets, yielding a 38% response rate. The participants included 536 males (76.5%) and 132 females (18.8%). The racial/ethnic composition of the sample was as follows: Caucasian/White (67.3%), Asian (11.1%), Hispanic (10.4%), Black (3.4%), Arab (1.4%), Native American (.4%), and a small percentage of physicians who described themselves as “other” (1.9%).

Results: Hierarchal regression indicated the overall model was significant for both steps of the regression equation. In the second step of the regression equation, the subscales of the LPSS predicted variance in physician stress beyond the variance accounted for by the demographic variables in step one (F (4,546) = 22.10, p < .001, R² = .24, ΔR² = .12). Notably, of the factors of the LPSS, the only significant predictor of physician stress was Personal-Life Satisfaction, B = .30. Personal-Life Satisfaction predicted stress substantially better than any of the demographic and practice variables, including hours worked per week.

Implications: Data showed personal life satisfaction, in contrast to components of work-related satisfaction, as a unique and robust predictor of physician stress. In other words, the degree to which physicians are satisfied with the quality of their personal lives, rather than their satisfaction with work, appears to influence their experience of stress as physicians. Findings suggest that interventions designed to improve personal life satisfaction and quality of life may be an effective strategy to assist physicians in stress reduction, which may, in turn, improve work performance.

Does It Come Around When It Goes Around? An Exploratory Examination of the Likely Effects on Physicians of Depersonalizing Attitudes Toward Patients

Author: Richard Bogue, University of Iowa

Introduction/objectives: A substantial body of research has accumulated on how physicians communicate with patients or are able to experience and show empathy with patients. In general, this body of research demonstrates that some physicians are better able to communicate with patients and to experience and show empathy. Important outcomes of these better communication skills are patient understanding of medical conditions, patient compliance with medical instructions and lower likelihood of the physician being sued for malpractice...even when something does go wrong.

What has not been well studied are the effects on physicians themselves from having and showing more empathy for patients, or less. Does depersonalizing one’s patients lead to poor outcomes for physicians themselves? If depersonalization of patients has negative consequences for physicians’ well-being, understanding and teaching this can provide additional support for communication competencies and emotional support skills. And if specific types of consequences can be identified, all the better. This study explores the possible impacts on physicians of depersonalizing attitudes and behaviors toward patients.

Methods: Data were gathered through the National Study on Physician Well-Being, which finished gathering and entering survey data in November 2012. A mail survey was sent to a random sample of US physicians. Specialties unlikely to practice in a hospital were excluded. 225 surveys were completed and returned.

The National Study included the Physician Well-Being Self-Assessment (PWSAT) which taps four domains of well-being: bio-physical (BIO), psycho-emotional (EMO), socio-relational (RELA) and religio-spiritual (SPIR). Each domain is measured by a 10-item scale, each of which have been found to have a high degree of internal reliability over a series of pilot studies. Initial evidence of external validity has been very promising but is not yet published. The survey also included The Maslach Burnout Inventory-Health Professionals (MBI-HP), which has been widely used and may be considered the gold standard in self-reported measurement of a health professional’s level of risk for burnout. The MBI-HP Depersonalization subscale indexes the level of depersonalization of patients that a physician is expressing about or toward her or his patients. Physicians can be categorized as at low, medium or high levels of depersonalization using standard benchmarks of the MBI-HP.

ANOVA will be used to assess the well-being of physicians who are depersonalizing their patients at low, medium or high levels. Where a significant relationship is found between physicians’ depersonalizing attitudes and behaviors and a domain of well-being (BIO, EMO, RELA or SPIR), a clustering technique will be used to identify the subset of measures in that domain that are most affected by the physicians’ depersonalization of patients.
**Communication Outside of Primary Care**

**Identifying illness uncertainty in veterinary clients accessing tertiary oncology care**

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**Introduction:** In a qualitative study involving a convenience sampling of 30 clients accessing oncology treatment for dogs at the Ontario Veterinary College from April to November 2009, semi-structured, audio-recorded in-person interviews were conducted followed by thematic analysis, a qualitative research method that identifies, analyzes, and reports patterns (themes) within data. With the objective of identifying client expectations, illness uncertainty - the underlying psychological driver of clients’ expectations - was also (adversely) identified.

**Results:** Uncertainty was the overarching psychological feature that dominated clients’ experience. Originating from the diagnosis of a serious, life-threatening cancer and its treatment, uncertainty had a profound impact on clients’ sense of a just and orderly world; their feelings, thoughts, behaviors, attitudes, and personal expectations in relation to their dog; and their expectations of the service. With uncertainty appraised mostly as a danger, clients employed multiple coping strategies to reduce it in the effort to adapt to the new reality of living with and caring for a dog with cancer. The need to manage uncertainty influenced their expectations of the service, specifically for information, ongoing relationships, 24-hour access, and timely service.

**Conclusions:** Oncology services need to be aware of the central psychological phenomenon of uncertainty, how it affects clients and influences expectations, and how services can and should do what they can to reduce, maintain or increase uncertainty, according to manageability, and in so doing, support client efforts to cope, enabling successful adaptation to the cancer journey.

**Summary:** This represents the first report of uncertainty in veterinary medicine. The practice of medicine is distinguished by uncertainty in relation to the limitations of professional knowledge, challenges of diagnosis, ambiguities of treatment and outcomes, and the unpredictability of patient response. The oncology setting is particularly beset with uncertainty due to the unpredictable nature of cancer and the complexities of treatment and outcomes.
Discharge Communication in Patients Presenting to the Emergency Department with Chest Pain - Defining the Optimal Content

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**Introduction/objectives:** In an emergency department, discharge communication represents a key step in medical care leading to improved patient satisfaction, adherence to medication, reduced anxiety and improved outcome. However, little is known about chest pain-patients’ understanding of their condition, retention of information and recall of instructions following hospital discharge. We therefore aimed to determine the content of discharge information in ED patients with chest pain that is likely to result, from the point of view of the caregivers as well as of the patients, in optimized outcomes.

**Methods:** We conducted an observational study in the Basel University Hospital, Switzerland. From a list consisting of 81 items, 47 physicians and three experts were asked to choose those to be discussed at discharge by selecting the items they would personally choose for an ED discharge communication with a patient with chest pain. Additionally, 51 patients suffering from chest pain were exposed to a subset of 34 items. Most frequently selected items were grouped into five categories.

**Results:** Identified categories were information on diagnosis (7 items), follow-up suggestions (9 items), advices on self-care (4 items), red flags (6 items), and complete treatment (10 items). In order to memorize these categories, the acronym “InFARcT” was created, containing the first letters of each category of standardized information.

**Discussion/implications:** Standardizing the content of ED discharge communication and providing a memory-aid could improve patients’ outcomes. This seems especially important for physicians working in the ED, as not only stress and time-constraints limit an optimal communication, but also the relative short experience of the vast majority of residents working in this field, in order to improve their communication-competencies for the benefit of thousands of patients seeking help suffering from chest pain.

The Impact of Team Effectiveness on Job Satisfaction and Burnout in Companion Animal Veterinary Practice

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A team approach has long been advocated as the most efficient way to deliver human healthcare (Heinemann & Zeiss, 2002; Temkin-Greener et al., 2004). In human healthcare, advantages of team delivery include benefits both for the organization as well as for individual team members, (Heinemann & Zeiss, 2002; Temkin-Greener et al., 2004). Since the provision of veterinary care also requires coordination and collaboration, it is anticipated a team approach would provide similar benefits. In contrast, teams with poor communication can result in job dissatisfaction and burnout in team members (Heinemann & Zeiss, 2002; Leiter & Maslach, 1988; Williams, Konrad, Scheckler, et al., 2001; Wallace, Lemaire et al., 2009). While these outcomes have been studied in veterinarians (Bartram and Baldwin, 2010; Hansez, Schins and Rollin, 2008), the influence of the team on these outcomes has not been performed in veterinary medicine.

A recent cross-sectional observational study explored the role of team effectiveness in the outcomes of job satisfaction and burnout within companion animal veterinary practice. Two hundred and seventy four team members from 48 companion animal teams from Southwestern Ontario participated in the study. Measures included a one item job satisfaction measure, the Maslach Burnout Inventory-General Survey, and a new Team Effectiveness survey. Mixed linear regression models were constructed to examine demographic and team effectiveness factors affecting job satisfaction and burnout.

While overall job satisfaction was 5.47/7 (N=265; SD=1.36; median=6.00), almost one quarter of participants were categorized into high risk categories for exhaustion and cynicism. Team effectiveness factors influencing job satisfaction and exhaustion included a toxic environment and individual engagement, while those associated with cynicism included a coordinated team environment, a toxic work environment, and individual engagement. The results of the study indicate team effectiveness significantly influences job satisfaction and burnout in veterinary team members.

Memorable Conversations in Neonatal Intensive Care: Interprofessional Provider Perspectives

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**Objective:** In this study, we explored the providers’ perspective of difficult conversations in neonatal critical care.

**Methods:** Between 2008 and 2011, interprofessional neonatal providers voluntarily attended the Program to Enhance Relational and Communication Skills-NICU workshops at Boston Children’s Hospital. At the beginning of the workshops, participants were asked to describe their experience with a difficult conversation in the NICU that was particularly challenging or satisfying. The narratives were analyzed according to a thematic analysis.

**Results:** We collected 74 narratives. Participants described memorable conversations that were exclusively challenging (n=51), both challenging and satisfying (n=22), and exclusively satisfying (n=1). We identified 5 broad domains (Infant’s Clinical Situation, Family Characteristics, Provider Characteristics, the Provider-Family Relationship,
and Satisfying Elements) and several themes that further characterized the providers’ perspectives.

**Discussion:** Understanding the practitioners’ experience with difficult conversations may help staff to anticipate some challenges inherent in neonatal discussions and to design communication and relational learning educational efforts.

**Teaching- Evaluation**

Improving communication in general practice when mental health problems appear, piloting a novel communication skills training course

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**Introduction:** About one third of patients in general practice present mental health problems. Many General Practitioners (GPs) report a need to learn better communication skills for consultations in which mental health problems appear. Studies have repeatedly shown improvement in physicians’ skills after communication skills training, but few studies have addressed skills specifically relevant to mental health problems in General Practice.

**Aim:** To design and test a mental health communication skills training for GPs in a Pilot Study.

**Method:** A 20 hours communication skills training was conducted with 21 GPs. The main content of training was a novel communication skill model with six potentially therapeutic skills:
1. Be sensitive to and explore patients’ hints, concerns and emotions.
2. Be explicitly empathic to emotional content.
3. Explore the patient’s perspective.
4. Explain possible cause-effect relations of the problem.
5. Assess the patient’s resources and strengths.
6. Promote empowerment by focusing on resources, strengths and coping strategies.

GPs conducted a consultation with a simulated patient before and after training. The consultations were videotaped. Behavior change was measured by comparing GPs’ number of skills related utterances before and after training. Self-perceived learning needs, self-efficacy and consultation time were also measured.

**Results:** Number of coded utterances applying the mental health skills, increased by 45% from before to after training. GPs increased their performance on four out of six skills, with medium to large effect sizes (ranging from 0.33 – 1.41). However, GPs’ self-perceived learning needs and self-efficacy did not change. The consultations were on average 3 min and 44 sec longer after training.

**Discussion and implications:** The results indicate that the communication skills training may change GPs’ communication behavior on skills relevant to mental health problems. Further studies should investigate if GPs actually use the skills in real consultations and if patients’ mental health is affected.

Training communication skills to deal with difficult emotions - desirable but hard to achieve

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**Introduction/objectives:** Emotional issues are a cornerstone of patient-centered communication and communication competence in general. Problems in patient-physician communication basically result from the physician’s inability to respond adequately to the patient’s cues and concerns – as well as from difficulties in dealing with own strong emotions. We developed a course to enhance in undergraduates the ability to handle difficult emotions in specific clinical settings. The course was integrated in the 4th year of the undergraduate longitudinal communication curriculum (CoMeD) of the medical faculty, University Dusseldorf and includes 4 units (4 x 2 h) of skills teaching in small groups with simulated patients.

**Methods:** In 2009 -2010 we conducted a prospective study with historical control to compare affective (emotional) related behavior between intervention group (41 subjects, probability sample) and control group (62 subjects, probability sample). Students completed 2 pre- and 2 post-intervention videotaped encounters with standardized patients. 409 videos were coded by blinded raters using RIAS (Roter 2002) and GR (Hodges & McIlroy 2003). Statistical analysis was applied repeated measurement. The primary outcome variable is the interaction effect between group and time of measurement.

**Results:** The intervention group showed a small increase in overall communication competence (GR-total number 15,85 compared to 14,96 points, F (1/98)=3,34, p=.07), but not in the GR-subscale for emotions/empathy. The rating of their affective behavior (RIAS; affective cluster, Ong 1998) showed no significant interaction effect between intervention and control group.

**Discussion/implications:** Besides the evidence for overall effectiveness of communication trainings for healthcare professionals the beneficial teaching of dealing with strong and difficult emotions in complex clinical settings still remains a tricky and unresolved problem. More time and more training courses may be needed to consolidate skills in emotional (self-) regulation.
Communicating reasons, risks, and regimen in prescription medication discussions: An intervention to teach the practice of prescribing

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**Introduction:** Clinician counseling about medication can improve patient understanding and adherence. This study developed a teaching session for providers concerning medication safety and tested the effects of the intervention at the physician- and patient-level. Hypothesized is that patients who received medication instructions from physicians who participated in the teaching session will report significantly higher quality of provider’s prescription presentation (QP3) than patients who received medication instructions prior to the session.

**Methods:** This was a single-site, prospective intervention study. For physician-level assessment, pre- and post-tests included a written case presentation. Learners also completed an objective structured clinical examination (OSCE). For patient-level assessment, the study included a cross-sectional observational design, including patient recall and satisfaction surveys before and after intervention.

**Results:** Twenty-nine physicians participated in the teaching session, focused on presenting patients the reasons, risks, and regimen of prescribed medication. In case presentation testing, physicians presented significantly more comprehensive information in post tests, t (27) = 4.55, p < .001, reflecting an improvement in communication about reasons and regimen. In OSCE (n = 14), all physicians presented risks and regimen information; however, 6 did no provide reasons.

In patient assessment, 44 patients completed surveys prior to intervention; 54 patients following intervention. In an analysis of covariance controlling for patient activation and communication satisfaction, there was no significant difference on QP3 between pre post test (estimated marginal mean 4.07). However, the covariates both had a significant association with the dependent variable: patient activation, F (1, 90) = 18.32, p < .001; communication satisfaction, F (1, 90) = 5.02, p < .05.

**Discussion:** In the academic test setting, physician presentation of medication information improved. However, patient recall of physician messages did not change following the intervention. While physician training did not influence patient perception, patient activation emerged as a critical influence on perceptions of medication discussions. Future teaching interventions should include strategies for the physician to increase patient activation.

Communication Skills Deficiencies Among Hospitalists

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**Introduction:** Strong physician communication skills can enhance patient safety and improve satisfaction. Our healthcare system increasingly elicits feedback from patients on their experiences as consumers, consistently revealing dissatisfaction with physician-patient interactions. We lack tools for identifying specific deficiencies and developing strategies for improvement.

**Methods:** The program consisting of three Standardized Patient (SP) cases was developed around complex communication issues. Individual cases geared toward improving patient satisfaction (based on a widely used clinical teaching tool for improving patient satisfaction “AIDET”), safety at time of discharge (based on a review of data for improving safety at time of discharge) and therapeutic bedside manner (based on characteristics of therapeutic behavior). 23 attending Internal Medicine hospitalists participated in each of three encounters. Deficiencies were defined as items for which less than 50% of participants performed adequately.

**Results:** For the patient satisfaction case, deficiencies were identified on all items related to managing up, explaining duration elements, and assessing patient understanding. The discharge safety case identified deficiencies in assessing patient understanding and addressing social barriers to discharge. Finally, the therapeutic bedside manner identified relative strength in items related to rapport-building and interpersonal communication.

**Discussion:** Using a novel SP exercise for attending physicians, we identified pervasive deficiencies in skills related to patient satisfaction, discharge safety as well as strong performance on professionalism and vocal and non-verbal communication style. We are in the process of assessing hospitalists’ attitudes about this program and correlating performance in our program with quality measures such as readmission rates and patient satisfaction (from HCAHPS survey). The reliability and generalizability of our results is limited by a low number of cases, a small n of participants and the uniform nature of participants (all were hospitalists at a large academic medical center).

What Are Internal Medicine Residents Missing? A communication needs assessment of outpatient clinical encounters

Authors: **Kristina Lundberg**, Emory University School of Medicine

**Introduction:** Few post-graduate medical education communication skills curricula exist and evaluation of communication skills is increasingly difficult. To guide curricular innovation, we performed a needs assessment of outpatient communication skills of internal
medicine (IM) residents, utilizing validated instruments for faculty observation, patient evaluation and resident self-reflection.

**Methods:** A convenience sample of PGY-2 residents in the Emory University School of Medicine IM Program was invited to participate. Using the SEGUE Framework, a checklist of medical communication tasks, faculty directly assessed residents during a clinic encounter. Immediately after the visit, the patient and resident each separately completed a modified Rochester Communication Rating Scale (RCRS), a 19 question Likert scale survey, assessing the communication during the encounter.

**Results:** Thirty out of 53 (57%) PGY-2 residents were assessed (43% male). SEGUE results indicate residents were most likely to “maintain patient’s privacy” (100%), “explore physical factors” (93%) and “check/clarify information” (100%). Residents were least likely to “explore psychosocial/emotional factors” (only 27%) or “discuss how health affects patient’s life” (53%). On the RCRS, patients gave lowest scores in “asked about issues that affect my health, like family, culture, finances…” and “Ask how the illness affects my life at home or at work.” Residents’ RCRS self assessments agreed with patients, scoring lowest on the two questions above. Residents also scored themselves low in response to “tried to understand how my patient sees his illness or problem.”

**Discussion:** Faculty, resident and patient data reveal that most PGY-2 internal medicine residents in a large, urban practice do not elicit important psychosocial information during outpatient clinic visits. Understanding the psychosocial context of a patient’s health is a skill needed to develop appropriate and effective medical plans. More observation and evaluation of residents’ communication skills is needed in order to guide further curricular innovation necessary to improve patient satisfaction and patient care.

**Provider Perspectives**

Predictors of attitudes toward empathic and patient-centered care among 4600 1st year medical students

Authors:
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**Introduction/objectives:** The ability to provide empathic and patient-centered communication has been shown to be a crucial component of high-quality and equitable care. The purpose of this paper is to describe and examine predictors of 1st year medical students’ beliefs regarding the importance of empathy and patient-centered communication for patient care.

**Methods:** Data for these analyses come from 4600 first semester medical students attending a stratified random sample of 50 U. S. medical schools. Students were invited to complete an online questionnaire that included measures of the students’ attitudes towards the value of various aspects of communication during encounters including the importance of empathy, assessing patients’ perceptions and opinions; determining patients’ beliefs, assessing patients’ psychosocial and cultural contexts; and understanding patients’ perspectives.

**Results:**: Predictors of higher scores all attitudes included being female, over 27 years old, having an undergraduate degree in social science or humanities (vs. STEM) and having higher scores on personal self-esteem and locus of control. Students in poor health had higher scores on the perceived importance of physician empathy but not on other measures. Student race and SES were associated with attitudes in bivariate analyses but were non-significant in multivariate analyses.

**Discussion/implications:** Medical student attitudes about the value of empathic and patient-centered care vary. Students who come from a STEM background may need more intensive education regarding the importance of these aspects of care. The relationship between self-esteem and locus of control and attitudes towards empathy and patient centered care suggest that students low on these factors may struggle with these issues more than those high on self-esteem.

Approaches to increasing empathic and patient-centered care Interventions that tailor their approach to pre-existing attitudes may be more effective than a single approach to all students.

The influence of attitude, motivation and confidence on patient-provider communication: learnings from behavioral studies

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**Introduction:** Over their years of experience and clinical observations, healthcare providers develop implicit, habitual, and often unconscious strategies in their approaches to the care of their patients, which are influenced by numerous factors above and beyond the evidence-based science (1). These factors include the providers’ attitudes, beliefs, assumptions, and confidence issues, and can unknowingly diminish the quality of healthcare provider’s engagement with their patients. In turn, these factors can undermine patient adherence, clinical efficiencies, and patient health outcomes. It behooves healthcare stakeholders to better understand healthcare providers’ implicit attitudes, beliefs, and confidence in order to optimize effective communications between patients and providers, and thus, healthcare outcomes.

**Objective:** To demonstrate, using evidence from multiple therapeutic areas, how behavioral and social sciences research methodologies can be used to assess and determine the influence of healthcare providers’ implicit emotions and attitudes in the clinical reasoning processes, and how these variables can impact the patient-provider dialogue and engagement.

**Methods:** Secondary analysis of published evidence from behavioral studies in multiple therapeutic areas, including auto-immune diseases, oncology, fibromyalgia, obesity, and diabetes.

**Results:** Findings demonstrate that emotional, underlying beliefs and motivational issues are found to influence the implicit clinical reasoning underlying the patient-provider dialogue and can impact the healthcare provider’s willingness and capacity to effectively and
Comparing Clinicians’ Perceptions and Barriers of Perinatal Palliative Care

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Introduction/objectives: Perinatal palliative care (PPC) is a comprehensive coordination of care provided by a multidisciplinary team to parents after a prenatal, life-limiting diagnosis. The team of clinicians works to provide supportive care for the infant and the parents during pregnancy, delivery, and newborn period. Effective teamwork requires understanding of the perceptions and barriers of the members. The aim of this mixed method study was to examine the perceptions and barriers of team members to this model of care and explore their similarities and differences.

Methods: In 2010 the Perinatal Palliative Care Perception and Barriers Scale was administered on-line to 300 medical professionals including physicians, nurses, and genetic counselors. Qualitative and quantitative analysis of the responses was performed.

Results: Perceptions of perinatal palliative care were positive by all groups. Barriers varied between the disciplines. The barriers were independent of years’ experience. Genetic counselors’ familiarity and personal comfort with PPC did influence perceptions and barriers. Significant negative correlations were noted between barriers and prior familiarity with PPC, personal comfort with PPC, and comfort with referral. Highest ranking barriers were lack of societal support and understanding, complexity in interdisciplinary communication, provider distress and helplessness, and lack of a coordinated palliative care team.

Discussion/implications: Clinicians report a variety of barriers; however, many are surmountable. Role definition and amelioration of barriers through team communication and cooperation may augment the accessibility of perinatal palliative care for families with a life-limiting prenatal diagnosis. These findings elucidate the barriers which exist in society and clinical practice to this interdisciplinary model of care. Expanding palliative care education to target perinatal health care providers may decrease clinician discomfort with parents in crisis and enhance understanding of how to create a more coordinated team approach. An active, personalized consultation process is ideal when working with parents facing a poor prenatal diagnosis.

‘No need to worry’: a qualitative study of best practices in reassurance according to primary care physicians

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Objective: Reassuring patients is regarded as an essential part of good clinical practice. However, there is limited evidence on effective ways to reassure patients in current communication literature. Therefore this study explored reassuring strategies considered effective by Primary Care Physicians (PCPs). More specifically we explored which goals PCPs pursue when reassuring patients, which actions they perform and through which mechanisms they believe these actions lead to their goals.

Methods: We combined two datasets consisting of stimulated recall interviews with PCPs. We re-analyzed an existing dataset, consisting of 15 interviews in which PCPs were asked to elaborate on their communicative actions while watching the recordings of two recent consultations. In the new dataset 12 PCPs were interviewed about two consultations in which reassurance was a specific goal.

Results: When reassuring patients, PCPs aim to influence patients’ emotions by creating trust, safety and comfort, which is considered reassuring in itself and a support for the acceptance of reassuring information. Second, PCPs aim to influence patients’ cognitions by undermining the belief in a harmful diagnosis, often followed by promoting the belief in an alternative, harmless diagnosis. PCPs described several mechanisms and belonging actions through which each of these goals could be accomplished, depending on the situation.

Implications: PCPs describe a wealth of reassuring strategies, being a valuable addition to current communication literature. This description may serve as a good starting point to guide doctors in choosing the most appropriate reassuring strategy depending on context and patient cues, to study its effectiveness in future experimental research and to train medical students and trainees in effective reassurance.
Social Media

What Role Should Healthcare Professionals Play in Patient and Caregiver Use of Online Health Communities? Results from a Qualitative Study

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Introduction/Objective: Approximately 25% of Internet users with chronic illnesses have sought health information through online health communities (OHCs). However, many healthcare professionals (HCPs) remain skeptical of patient-generated health information, and individuals are becoming less likely to share this information with them. This study sought to understand how HCPs react when individuals share OHC content and to identify the preferred role for HCPs among patients and caregivers who use OHCs.

Methods: We conducted in-person and online focus groups with members of verified OHCs (n=89), such as PatientsLikeMe.com and Exchange.WebMD.com. A trained moderator conducted each group and asked about OHC membership, HCP reactions, and the roles of both OHCs and HCPs in health decisions. Two researchers independently coded transcripts with NVivo 9.2, and we conducted thematic response analysis.

Results: Most participants described OHCs as a way to supplement information from HCPs, whom they often described as too busy to have detailed treatment discussions or to discuss self-care activities. Although half of participants reported sharing OHC information directly with HCPs, others used OHC content to inform healthcare discussions.

Participants reported that most HCPs reacted negatively to OHC information. Many recalled HCPs discounting the Internet as a reliable source and discouraging them from seeking health information online. Participants perceived HCPs as feeling professionally challenged by such discussions, and many participants described the experience as disempowering.

Despite negative reactions, most participants explained that they value HCPs’ feedback on OHC information, consider HCPs a more credible information source, and want to make health decisions in tandem with HCPs.

Discussion/Implications: Although many HCPs seem to discourage OHC participation, individuals both desire and value feedback from these professionals on OHC content. HCPs who review OHC information with patients and caregivers can identify what information is credible and help them to make more informed health decisions.

Usability testing of a web-based question prompt sheet for the initial follow-up consultation after surgery for esophageal cancer

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Objective: To develop and test the feasibility of a web-based list of example questions (i.e., a question prompt sheet, QPS) for the initial follow-up consultation after surgery for esophageal cancer. The QPS aims to increase patient participation and to enhance the information provision regarding future quality of life.

Methods: We examine (1) the usability of a prototype (n=8), (2) patients’ evaluation of the usability and usefulness (n=40), and (3) clinical feasibility (n=22). Each previous phase produces a modified QPS which is then tested in the subsequent phase. In study 1, we asked purposefully selected patients who had undergone surgery, to think aloud whilst using the QPS. Patients were surveyed afterwards. We then categorized audio taped comments, and changed the QPS accordingly. In study 2, we invited patients to independently use and evaluate the modified QPS. In study 3, 20 patients and 2 surgeons will use the QPS in the initial follow-up consultation.

Results: For study 1, eight patients (6 male, age range 51-70) were interviewed (mean 1h 45m). We obtained 454 individual comments (187 positive, 214 negative, 27 neutral) and 91 explicit suggestions for improvement. Most comments were related to: (1) the introduction of the QPS, (2) navigation, (3) the arrangement of example questions, (4) instructions, and (5) shutting down the QPS. All patients perceived the QPS to be very useful, and many proposed to extend its use to other consultations. Most patients did not find the QPS burdensome. Data collection for study 2 is ongoing.

Implications: Study 1 shows that a web-based QPS is usable and considered useful if changes are made to enhance patient-friendliness. Results of study 2 and 3 will further determine the feasibility of a web-based QPS.

Using Facebook Communities for Health Activation: A Survey Study

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Objective: Examine the extent to which Facebook (FB) replicates dimensions of F2F (F2F) communities important for patient activation (e.g., assertiveness and confidence in managing one’s own health).

Methods: Participants recruited from on campus and online interest groups about health and online research. Survey items included multiple choice questions regarding participants’ demographics and FB use and Likert items about level of health activation F2F, quality
of FB community, and level of health activation on FB. I calculated Pearson’s correlation and Kruskal-Wallis H statistic.

Results: 457 US citizens responded, ages 18-29 (34%, n=196) and 30-39 (27%, n=155). 77% (n=445) female; 16% (n=91) Hispanic; 78% (n=452) white. Household income (HHI): $20K-$45K (21%, n=123); $45K-$65K (20%, n=119); $65K-$125K (36%; n=188). Most checked FB hourly (20%; n=103) or daily (58%; n=299). Most agreed that they exchange health advice with family and friends (81%; n=370), encouragement to seek medical help (87%; n=397), and trust (61%; n=278) with their FB friends, whom they consider part of their community (60%; n=274). However, most disagreed that they use info from FB postings in their health decisions (73%; n=333). Age was slightly associated with likelihood of FB friends influencing health attitudes (p value: 0.054, H statistic: 5.833, df: 2) and health decisions (p value: 0.016, H statistic: 8.328, df: 2); HHI, with sharing health experiences and knowledge on FB (p value: 0.045, H statistic: 11.369, df: 5); and frequency of FB use, with FB health activation (p value: 0.001, H statistic: 13.44, df: 2).

Conclusion: FB has potential for extending social influence for health behavior change, depending on the age, frequency of use, and level of health activation in F2F networks. FB may not help reduce health disparities involving race, ethnicity and low-HHI. Privacy issues, financial cost, and disparity between FB and F2F network composition may be barriers.

“I Can Do All Things Through Jesus”: Daily Inspirational Text Messages for African-American Women with Diabetes

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Introduction: Many patient-provider communication interventions are effective but expensive. The ubiquity of cell phones and text messaging allows for potential new tools for diabetes patient support.

Methods: The Call2Health study explores strengths-based text messaging to improve diabetic health outcomes for underserved African-American women. Forty-seven women were recruited from a general outpatient clinic at the University of Virginia and randomized into one of two groups. Both groups received self-selected daily-personalized text message reminders and affirmations to support their health care and behavior goals. Both groups also received “Buddy Texts,” or strengths-based prompts to stimulate self-reflection or conversation. Women in the second group were also invited to participate in bi-weekly drop-in sessions for group support and diabetes education. Both groups underwent the six- to nine-month intervention and all participants used their own cell phones to receive text messages. Our primary outcome is hemoglobin A1C levels; secondary outcomes include changes in daily self-care activities, locus of control, social support, diabetes distress, quality of life, well being, and diabetes knowledge.

Results: 10,620 text messages were sent, with common messages being “I am able to do all things through Him who strengthens me. (Philippians 4:13)” and “Eat less. Move more.” The majority of women selected texts from the Bible. At enrollment, the mean HbA1C = 7.7 (sd=1.54) and mean BMI = 40.7 (sd=9.06). We are currently collecting and analyzing primary and secondary outcome data. Exit interview data reveal that women found the daily text messages very helpful as reminders to take medicine, test their blood sugar, or to help them “stay on track.” Some forwarded their messages to friends. They also reportedly enjoyed the weekly Buddy Texts because they were “different” and uplifting.

Discussion: A very simple daily text message intervention may have a significant impact on diabetes self care among rural, underserved African-American women.

Cáncer de Seno en Twitter: A Network and Content Analysis of Social Support Spanish Language Breast Cancer Twitter Talk

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Breast Cancer is one of the highest causes of cancer deaths among Latina women in the U.S. and Latin America. In Latino culture social support networks provide interpersonal emotional support, however sufficient informational support may be scarce. This study applies network and content analyses to examine the type and network structures of breast cancer support in Spanish on Twitter. Five data sets of Twitter networks were collected using the Spanish search term “cáncer de seno” (breast cancer) were collected. A total of 1,824 users, 2,170 tweets, and 3,249 following relationships were analyzed for network structure and type of support. Findings indicate that informational support was significantly the most common type of support that users exhibited, indicating that they used the Internet to complement the existing emotional support Latina individuals with breast cancer often receive outside the Internet. The primary sources of information were media organizations on Twitter. However, rather than conveying news about breast cancer (e.g., medical advances and treatment), they reported about the participation of celebrities in breast cancer campaigns. The analysis also reveals that support type was associated with network structure. Specifically, we learned that users expressing of support of any type were more likely to interact with others who talk about breast cancer, than users posting non-support messages about the topic. Replicating behavior outside the Internet, Twitter users exhibiting emotional support were more likely to belong to a group (i.e., a network cluster), than users posting non-support messages about the topic. Implications for researchers and the healthcare community are discussed.
Language and Cultural Differences

Integrating Type 2 Diabetes Nutrition and Chinese Medicine’s Xiaoke Food Recommendations to Create Innovative Diabetes Dietary Health Education

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Introduction/objectives: Type 2 Diabetes is an increasing health problem. Research has demonstrated that dietary/food habits are difficult to change. Many Chinese Americans have food/eating habits that stem from Chinese medical concepts such as yin/yang and hot/cold. In the U.S., Chinese medicine education does not standardize food treatment. This study examines and compares “xiaoke” (a close equivalent to diabetes) with biomedical diabetes to determine places of overlap and possible integration.

Methods: Ten semi-structured interviews were conducted with professional and lay Chinese medicine experts in English, Mandarin, and Cantonese. Participants included licensed acupuncturists and unlicensed Chinese medicinal herb Shopkeepers and laypeople with food/health knowledge and experience with type 2 diabetes. Interviews were transcribed and translated. Data were analyzed with discourse analysis and constant comparison regarding diagnosis. Treatment suggestions were divided into Chinese medicine suggestions versus biomedical suggestions. A licensed acupuncturist and registered dietitian examined places of overlap to create an integrative diet.

Results: Xiaoke differs substantially from diabetes because illness symptoms refer to dysfunctional digestion in upper (lungs), middle (stomach) or lower (kidney). Similarly, food treatments affect the two diseases differently. For example, cooling vegetables such as leafy greens or cucumbers are suggested because Xiaoke typically manifests itself as too much heat. From a biomedical perspective, these vegetables are also good because they are low in fat, calories, and carbohydrates and high in fiber.

Discussion/implications: For Chinese-Americans (and perhaps others) who believe in Chinese medicine, an integrative diabetes diet may be more persuasive than a purely biomedical one. By framing biomedical dietary suggestions around Chinese medicinal food and eating practices that are already familiar, this diet could be tested to determine if it is a more culturally-appropriate health education intervention.

The “good interpreter” in medical consultations: the “dos and don’ts” of a supposedly neutral agent

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Introduction: Linguistic and cultural differences are among the most important difficulties encountered by physicians. These difficulties might be handled in collaboration with an interpreter. We set up a research to explore representations of the work with interpreters among family physicians in Quebec City. This paper aims to present analysis of physicians’ discourses about “the good interpreter.”

Methods: Focus-groups with third year medical students (6, N=22), residents (4, N=29) and senior physicians (5, N=47) were conducted. First, each physician was told to describe individually what a good interpreter is and participants could respond to each other. Second, the two video vignettes were projected and separately discussed. Discussions were audio recorded and transcribed.

This presentation focuses on the first part only. Thematic analysis is performed on discussion about the good interpreter. Emerging themes were coded and their frequencies were analyzed to determine the relative importance of the themes for all participants and for specific statuses (students, residents and seniors).

Results: For all physicians, the major organizing theme is accuracy/validation of interpreter’s translation. From this theme participants position themselves on what the interpreter can and can’t do in medical consultations. Students discuss mostly interpreter’s roles. Finally, much more themes emerged in seniors’ discourse. These themes concern many aspects of interpreter’s and physician’s roles and broader characteristics of interpreted consultations.

Discussion: In coherence with previous results of the same study, discourses vary qualitatively according to status even before submitting participants to the stimulus (video vignettes). Results also suggest that senior physicians generate spontaneously more complex representations of working with an interpreter than other statuses. Present findings contribute to the understanding of the relation between medical socialization processes and healthcare of linguistically and culturally different others.

Keywords: Medical interpreting, thematic analysis, patient-physician relationship, intercultural healthcare
What do physicians depict in gestures to non-native speakers? Partial understandings can become mixed blessings

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Introduction/objectives: In clinical encounters with patients with limited proficiency in the language of the interaction, a language barrier can compromise mutual understanding. Physicians regularly supplement their speech with hand gestures, which research shows are suited to depicting imagistic or spatial referents and which can provide information that is not conveyed in words. Although primary research on gesture use has addressed this gesture-speech interplay, there is little health-related research on physician gestures, let alone an exploration of implications. We analyzed gesture-speech interplay in videotaped interactions between specialist physicians in Norway and patients with limited Norwegian proficiency. Research has shown that adherence to treatment plans is a particular challenge for non-native speaking patients; thus analysis focused on discussions of actions patients should do in the future.

Methods: Using videotaped material of in-hospital interactions, we selected eight encounters with patients who had limited Norwegian proficiency. We used the framework of Conversation Analysis in combination with Microanalysis of Communication. After locating all hand gestures, we focused on those with handshapes/motions complementing accompanying speech (i.e., iconic gestures).

Preliminary Results: Iconic gestures illustrated an array of referents, both concrete (e.g., actions, body parts, symptoms) and abstract (e.g., regularity, increase or decrease, timelines). In many cases, what gestures depicted was less specified verbally; however, the words provided necessary context. While referents could be readily identified (e.g., showing the location of the liver), how those referents should be understood depended on verbal contributions. Patients often demonstrated understanding of information presented in gesture, but rarely information presented in speech.

Discussion/implications: While gestures provide immediately accessible demonstrations to non-native speaking patients, patient understanding of a treatment plan depends on integrating what was conveyed in both words and gestures. Physicians should be aware that patient signals of understanding of information from gestures could be misleading when that information depends on context provided by the words.

An Innovative IPE Program to Target Culturally Competent Communication for Students in Nursing and Pharmacy

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Rationale: Healthy People 2010 identified lack of cultural competence in healthcare delivery as a key factor leading to health disparities. To remedy the situation, accreditation organizations for Nursing, Pharmacy, and other health professions require programs to prepare practitioners for serving culturally and linguistically diverse populations. Another common curriculum need of health professional programs is interprofessional education (IPE).

Objective: To address both needs, an interdisciplinary team of faculty members from Nursing, Pharmacy, and Health Communication designed, implemented, and assessed an IPE program focusing on Culturally Competent Communication (CCC) for students in nursing (N=80) and in pharmacy (N=80). The two 2-hour sessions of team-based learning used lectures, case studies, educational videos, and reflective problem-solving activities in teams, designed to address competencies related to CCC, Interprofessionalism, and Team Work.

Method: Quantitative survey data collected at baseline and post-assessment measured Cultural Competency (including subscales of Perceived Skills, Perceived Knowledge, Confidence in Encounter, and Attitude), and Actual Knowledge related to CCC. All instruments were reliable at or higher than .70 both. Qualitative survey data were collected to examine students’ perceptions related to the IPE experience.

Results: The IPE program significantly increased students’ Cultural Competency on all the measured subscales and Actual Knowledge (p<.001, see Table). The qualitative data suggested that students appreciated the opportunity to learn with, from, and about the other profession. The case analyses facilitated team-based learning and enhanced reflective and problem solving skills.

Conclusion: The innovative IPE program successfully achieved the targeted competencies related to cultural competency and interprofessionalism.
Encounters with Difference: Language Labs for Second Year Medical Students

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Introduction: With increasing diversity of the local patient population, there is a growing need for doctors to develop skills for communicating with people from a wide range of cultural backgrounds. Exposure to different languages and cultures may enable doctors to build rapport with patients and families from backgrounds which are different to their own.

This paper describes the development of a series of “language labs” for undergraduate medical students at Leeds Medical School. The aim was to teach students key phrases and principles of British Sign Language, Urdu, Punjabi (Mirpuri), Bengali (Sylheti), African (African French, Tigrinya), Chinese (Cantonese and Mandarin) and Polish. It was not intended to make students in any way proficient in the language but to enable a warm and professional start to a consultation. The languages were chosen following a review of the demographics of the local population and consultation with ethnic minority groups. Language labs were facilitated by a range of local people from these backgrounds.

Methods: All second year students were able to select two workshops from the above languages, and video podcasts were made available to them on our Virtual Learning Environment with on going access after the sessions. The language labs enabled the students to practice eleven basic phrases/questions so that as future doctors they will be more welcoming to diverse patient groups and better able to build a mutual rapport, thus helping to facilitate the process of “the capacity to live with difference”. The session only covered the beginning and ending of a consultation as the middle part, working with an interpreter, is covered later in year 3.

Evaluation by students and tutors has been positive. Key aspects of the evaluation and lessons learned will be shared. Further long-term evaluation will be available.

Adherence

Considering the effective elements of health communication interventions to improve chronic disease management: what does the evidence indicate for adherence?

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Objectives: Few studies to improve adherence have tailored interventions to individual characteristics, with little consideration of the communication features that promote behavior change; elements of the intervention itself have not been systematically studied or evaluated. The need to customize appropriately is essential - but by whom, where, for how long? To target patients with personalized interventions with the highest probability of success, understanding what works with other health-related behaviors provides guidance.

Methods: A systematic review was conducted of tailored/targeted strategies (using MEDLINE and Embase). Inclusion criteria: peer-reviewed, published articles, in English, 2000 - 2012; 77 studies included a range of behavioral outcomes (medication adherence, preventive screening, health promotion, self-management of disease). Although drawing upon broader work on “person x intervention” approach to behavior change, this analysis is restricted to elements for which interventions were customized (delivery by whom, channel, material/content, dose/frequency, setting).

Results: Over one-half of studies reported significantly beneficial effects associated with discrete intervention features. However, the frequency of the characteristic utilized was not associated with its statistical significance. For example, while health educator was used most often (26.7%), computer algorithm/generated message and physician were most effective (80.0%); print was most common (32.9%), yet more studies of interactive online and audiovisual medium demonstrated significant improvement (77.8%); with home reported most often (57.7%), although churches and workplaces were more successful environments for behavior change (80.0% vs. 66.1%). Additionally, within group differences were found, with some effects moderated by individual-level factors.

Discussion/implications: This study presents a growing body of science regarding optimal features when creating health communication interventions. By providing an empirical base to guide intervention development to improve medication adherence, using patient-centered strategies that appropriately match what has worked and for whom, these findings can be used to accelerate effective behavior change strategies via an evidence-based approach to chronic disease management.

Tailored health information and its role in improving diabetes management for older adults

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Introduction/objectives: By 2030, 71.5 million Americans will be age 65 or older, most having one or more chronic health conditions that require self-management or assistance in managing. The study explores the use of a novel health information platform to promote self-management of diabetes by older adults in a rural setting.

Methods: The researchers developed an online information and self-management resource adapted to the needs of active middle age and older adults. The application included individually tailored health information, online health trackers and a dedicated social network. In the summer of 2011, through local primary care clinics, 160 diabetic patients in rural Midwestern United States were recruited for a five weeks pilot trial. Individual diabetes management practices and ap-
Introduction: Blood pressure (BP) control remains a substantial concern, particularly among African-Americans. Studies examining reasons for poor BP control and testing behavioral interventions, largely driven by biomedical frameworks, have varying levels of success. However, we recognize a missed opportunity to learn from patients who have successfully controlled their BP. This study sought to ascertain strategies for success through hearing patients’ stories.

Methods: We collected stories from African-American Veterans who had achieved BP control in the past year at 3 Veterans Affairs Medical Centers. We conducted open-ended qualitative telephone interviews with 30 Veterans, asking them to tell about a critical ‘Aha!’ moment when they realized they needed to control their BP and their strategies and behaviors to improve their BP control. From these, we selected 15 Veterans to participate in video-recorded interviews, in which they were coached on how to tell a detailed, compelling story about their experiences learning they had high BP, their ‘Aha!’ moment and how they managed their BP in their daily lives. We used a narrative analytic approach to identify narrative themes about how patients move through their lives managing their BP.

Results: Engagement with the online application influenced people’s attitudes and behaviors regarding diabetes management, with users being about 2.5 times more likely to have high self-efficacy about their diabetes over non-users, seven times more likely to monitor their glucose than prior to enrollment, and nine times more likely to closely monitor their overall health. Some users acknowledged significant behavioral changes in diet as well as amount of daily exercise, and more confidence in their capability to manage their diabetes and openness to discuss it with family and friends.

Discussion/Implications: The use of tailored health information in the context of a system which addresses the multiple communications, tracking and information needs of older adults could be of real benefit in promoting improved self-management and a higher quality of independent living.

Hearing stories: Identifying key strategies for successful blood pressure control within the context of individuals’ daily lives

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Introduction/Objectives: Our study objective was to develop and test the efficacy of an evidence-based, enhanced prescription drug container label design to improve patients’ understanding and use of their medications.

Methods: A two-arm, randomized controlled trial was conducted at one central-fill community pharmacy serving 11 community health centers in the greater Washington D.C. area. A total of 429 English-speaking patients and 417 Spanish-speaking patients taking multiple prescriptions drugs were recruited. Those in the intervention arm received their medicines with a patient-centered label design that included a Universal Medication Schedule (UMS) to provide explicit instructions on when to take their regimen (Morning, Noon, Evening, and Bedtime). Those in the usual care arm received a standard label. Baseline, 3 month, and 9 month interviews were conducted assessing functional understanding (times per day, pills each time, spacing) of prescribed medicines. Self-reported adherence was measured using the Patient Medication Adherence Questionnaire (PMAQ).

Results: While no differences in medication understanding were found at 3 months, those whose prescribed medications were dispensed with an enhanced label design were better able to demonstrate understanding at nine months as measured by times per day (Odds Ratio (OR) 2.17, 95% CI 1.36-3.45, p = 0.001) compared with patients receiving usual care. Those with limited literacy demonstrated a disproportionate benefit, with 87.5% properly understanding correct times per day of their medicine in the enhanced label study arm compared to 75.8% receiving usual care (p=0.04). At nine months, those receiving the intervention demonstrated lower average non-adherence across their medicines (9.5% vs. 14.5%, p = 0.001) compared to patients receiving standard labels.

Discussion/Implications: Our study provides evidence that patient-centered labeling on prescription containers including a Universal Medication Schedule can improve patient understanding and self-reported adherence.

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Effect of a Patient-Centered Drug Label to Promote Patient Understanding and Adherence to Complex Drug Regimens

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Medication Misunderstanding and Non-Adherence in Kidney and Liver Transplant Recipients: The Role of Health Literacy

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Background: Transplant recipients must take highly complex medication regimens and lifelong immunosuppression (IS) to preserve graft function. The study objective was to determine the prevalence and risk factors for medication misunderstanding and non-adherence and the relationship of health literacy to these outcomes among liver and kidney transplant recipients.

Methods: Structured, in-person interviews with 204 transplant recipients; kidney (N=99) and liver (N=105) were conducted at two transplant centers in Chicago, IL and Atlanta, GA from 2011 to 2012. We assessed basic demographics, medication adherence, and functional medication understanding. Health literacy was measured by the Rapid Estimate of Adult Literacy in Medicine (REALM) and Newest Vital Sign (NVS). A chart review was conducted to obtain clinical outcomes.

Results: The mean age of participants was 54.8±13.3 years, 69% were non-hispanic white, 24% high school education or less, and 21% had household income less than $20,000. On average, participants took 10±4 medications and 40% had a medication change in the past month. A total of 19% had inadequate medication indication knowledge, while 40% incorrectly dosed out medications. Limited literacy was present in 20% of patients as measured by REALM and 38% by the NVS. One quarter of patients was non-adherent by self-report and 28% by biologic measure. In bivariate analyses, inadequate indication knowledge (OR 2.9, 95% CI 1.4-6.2, p<.01) and inadequate dosing understanding (OR 2.4, 95% CI 1.3-4.4, p<.01) were associated with hospitalization. In multivariate analyses, after adjusting for relevant covariates, limited literacy independently predicted inadequate indication knowledge (OR 2.8, 95% CI 1.1-6.8, p<.05) and non-adherence by biologic measure (OR 2.8, 95% CI 1.1-7.3, p<.05).

Conclusions: This is the first known study examining whole regimen medication adherence and functional medication understanding in transplant recipients. Limited literacy was an independent risk factor for medication misunderstanding and non-adherence, while medication misunderstanding was associated with hospitalizations.

Team and Interpersonal Communication

A Review of Instruments to Measure Communication in Team-Based Care

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Introduction/Objectives: Health care is continually evolving towards models of team-based care, and as health care delivery systems become more integrated and efficient, tracking and measuring implementation of team-based care for research, evaluation or quality improvement is much needed. Existing tools that measure team-based care often focus on settings other than primary care, uncommonly evaluate patient experience, and are often atheoretical or lack demonstration of adequate psychometric characteristics. Given this gap, this project, funded by the U.S. Agency for Healthcare Research and Quality aims to develop a conceptual model of team-based primary care and identify, review and map measures to the model. The focus of this presentation is to provide a review of the existing instruments and measures to assess communication in team-based care.

Methods: To identify instruments and measures of communication in teams we explored several sources, including: measure databases (e.g., NQF, Nat’l Quality Measures Clearinghouse, HHS Measure Inventory, NIH GEM database), Measures Application Partnership, and CAHPS. We also sought input from experts in team care, examined reviews of team care measures, and completed a review of the peer-reviewed and grey literature on both teamwork and team-based primary care.

Results: The following are preliminary results. We identified nearly 60 instruments that measure communication in health care teams. Approximately half of the instruments were developed in or are for use in general practice or primary care settings. The majority of measures identified are surveys or observational checklists and related tools. The instruments have measured attributes of teamwork from the perspective of individuals, teams and patients. The review will be completed by July 2013; the full results will be presented at the meeting.

Discussion/Implications: As health care delivery continues to evolve toward models of team-based care, having measures to understand, evaluate and improve communication in teams will be instrumental to future progress.

Disclosure Statement: This research was conducted under contract to the Agency for Healthcare Research and Quality (AHRQ), Contract No. HHSA 290 2010 00004I, Task Order #5, Rockville, MD. The authors of this article are responsible for its content. No statement may be construed as the official position of the Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services. Financial support for this study was provided by AHRQ under contract No. HHSA 290 2010 00004I, Task Order #5.
Empirical Analysis of Group Communication Processes among Multidisciplinary Bone Marrow Transplant Teams’ in Cancer Center Team Meetings

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Objective: The objective of this study was to determine team meeting communication processes used by the Bone Marrow Transplant (BMT) Inpatient and Outpatient teams to discuss patient care at a large faith-based cancer center in the Southeastern United States. This paper discusses the Group Relations communication process, which is one of the two inductively derived communication process categories identified in the study.

Methods: Ethnography methods, a grounded theory approach, member checking in and an 8mm video camera placed in plain view of the group to record 4 inpatient and outpatient team meetings were used for this study.

Results: Group relations communication deals more specifically with group dynamic processes that work interdependently with patient care processes described elsewhere in this study. Group relations communication process consists of the task role dimensions and social emotional role dimensions that in part define group life. The group relations communication process has three sub-processes, a) task communication, b) socio-emotional communication and c) intermediary communication. The task communication sub-process has one subtype communication: instruction-direction talk; while the socio-emotional communication sub-process has three subtypes: social talk, praise talk and humor talk; and the intermediary communication sub-process has one sub-type: question and answer talk.

Practice Implications:
1. BMT team leaders must be willing develop group facilitation skills in order to assist other team members to communicate effectively across complex boundaries in bona fide groups.
2. Designated BMT team leaders need to help the group differentiate roles among its team members. The BMT team leader is not able to meet all task and socio-emotional needs of the team members and as such should authorize, empower, and delegate responsibility to team members.
3. Multidisciplinary BMT teams need to know and understand better, how group relations communication process works interdependently with patient care interventions.

The importance of communication styles in interdisciplinary cooperation in community-based oncologic care - a mixed-method study

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Introduction/Objectives: Care of oncology patients should be organized in multidisciplinary teams, including oncologists, radiologists, organ-specific physicians, psychologists, nurses, and other health care disciplines. In academic medicine this is common practice. It is not necessarily the standard-of-care in community settings. To identify the current situation of patients with urological cancers in community settings in Germany we conducted a mixed-method study. The aim was to identify the prevalence of cooperation among German community-based urologists in the care of patients with malignant tumors and to identify barriers and facilitators for cooperation.

Methods: The study consisted of a mailed survey to most community-based urologists in Germany (N=1,925) and of in-depth interviews with urologists and oncologists (N=40) who cooperate. Quantitative analysis included descriptive statistics and multivariate analysis. In-depth interviews were thematically analyzed.

Results: Participants mostly worked in single-practice (48%) or with other physicians (44%). Approximately 60% of them cooperated with an oncologist. They cooperated to offer additional therapies and to improve patient outcomes. Of those that cooperated most knew their partner well (78%). Overall care tended to remain with the urologist (61%). Most participants thought that cooperation would improve patient outcomes (80%). The in-depth interviews revealed that community-based physicians worked with a myriad of physicians. Decisions to cooperate were pragmatically based on patients’ cases. Physicians’ judgments on the quality of the cooperation were largely based on communicative aspects of the cooperation.

Discussion/Implications: Community-based urologists in Germany believe that cooperation with other physicians in their care of patients with urologic tumors improve patient outcomes. However, only some cooperated. In-depth interviews showed that cooperation was mostly organized opportunistically. Simple, effective communication styles that ensured quick conveyance of patient information across practices and joint treatment discussions were fundamental for successful cooperation. Policy incentives to increase community-based interdisciplinary cooperation needs to include simple, effective communication structures.

Internal communication in wards with high and low patient satisfaction

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Introduction: Good patient communication contributes to better health outcomes, greater patient satisfaction, shorter treatment times, fewer complaints and a more efficient resource use. Good
communication between management and employees is conducive to lower absenteeism as well as greater employee satisfaction and commitment. These two realisations converge in a study of the relationship between the internal communication of hospital staff and patient satisfaction.

Methods: A qualitative study of the communication culture in wards with high and low levels of patient satisfaction was carried out over an 18-week period, answering the question: What characterizes the internal communication in wards with high and low patient satisfaction? The methodology employed coupled qualitative research interviews with observational studies of managers and staff interacting with colleagues and patients. The results identified a need for further investigation in the field of hospital management communication, which was the issue of a similar qualitative study entitled: Management's role in communication culture.

Results: Patients overhear a good deal of internal staff communication and have a clear sense of what the mood in the department is. As a result, internal communication must also be developed in order to enhance the patient experience and increase patient trust. A strong communication culture beneficial to both patients and employees comprises: 1) common guidelines for shared communication; 2) articulated communication; 3) meta-communication; and 4) feedback. The management is responsible for the communication culture. The studies show how management communicates in a ward with high patient and employee satisfaction, and what goes wrong when management communicates poorly.

Discussion/Implications: Solely examining the quality of individual patient conversations is not enough to achieve the human and financial benefits of good patient communication. This presentation discusses what comprises a strong communication culture and how it can be strengthened for the benefit of both patients and staff.

“I beg your pardon?” - Nurses’ experiences in facilitating doctors’ learning process.

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Introduction/Objectives: In Belgium, family physicians (FPs) are assisted by nurses from specialized palliative home care teams (PHCTs) in caring for their palliative patients. Previous research indicates FPs’ learning from these nurses during collaboration (workplace learning). We trained PHCT nurses in communication techniques to facilitate FPs’ workplace learning behavior and learning process. It is not known how the nurses experience this new task and how they manage to perform during the everyday collaboration with FPs.

Methods: Semi-structured interviews were taken from 28 PHCT nurses one month after the training. Topics that were discussed: what goes well and what doesn’t; how do you feel in this new role; how does the training affect your work? Thematic analysis was done by two researchers.

Results: Five major themes emerged from the analysis: 1. Interprofessional relationships; 2. Personal style and behavior; 3. Quality of patient care; 4. Professional growth; 5. Team dynamics.

Discussion/Implications: Communication training of one health care team member (the nurse) seems to lead to behavioral change of all professionals involved. The training added the role of ‘teacher/trainer’ to the previous role of ‘consulted expert’ for the nurses. This induced a tendency towards reflective practice with FPs. Some nurses mentioned a loss of spontaneity when applying certain communication techniques. Peer discussions within the nursing team helped to overcome this barrier. The shared focus on quality of patient care initiated collaborative discussions resulting in mutual respect for each other’s views and responsibilities. Nurses felt more comfortable in discussing medical policy with FPs.

Training PHCT nurses can foster conditions for workplace learning for FPs. Further research is needed to evaluate the effect on the learning outcomes of FPs.

Risk Communication and Genetic Counseling

Disclosure Dynamics with a Diagnosis of Hypertrophic Cardiomyopathy

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Introduction: Hypertrophic cardiomyopathy (HCM) strikes 1 in 500 people and is the most common cause of sudden cardiac death in children, notably those regularly participating in exercise and sports. Sometimes, sudden death is the first sign. As a hereditary illness, recent developments in genetic testing now facilitate a diagnosis that would allow for preemptive measures to manage the condition and plan for a life with illness. The purpose of this study was to explore the disclosure experiences of individuals diagnosed with hypertrophic cardiomyopathy.

Methods: Respondents provided open-ended responses to an online survey. Using a grounded theory approach, we analyzed the responses of 315 individuals diagnosed with HCM to questions inquiring about the nature and role of disclosure communication with biologically-related family members.

Results: The following themes emerged from the analysis: 1) the need to encourage testing, 2) the need to share a sense of concern, 3) disclosure as an obligation, 4) disclosure as responsibility and 5) disclosure as potentially subjective. Participants also described disclosure as imperative health communication with the focus on the family members.

Discussion/Implications: The findings begin to fill the void about disclosure dynamics for individuals with HCM and provide meaningful, actionable understanding. Future research needs to examine why some individuals choose not to disclose, how individuals decide to whom to disclose and to whom not, what is withheld during disclosure and whether disclosure is a singular event or an evolving process. Similarly, future research needs to explore how individuals and family can simultaneously provide emotional and social support while exchanging health information. Clearly, HCM merits much study; the
researchers encourage the development of a research agenda that is informed by researchers, health care providers, and most important by individuals and families living with HCM.

Investigating the Effectiveness of Patient Summary Letters in Clinical Genetics

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Background: Clinical genetics services offer diagnosis, genetic testing, health surveillance, and education to patients and families with genetic disorders. Unlike other areas of medicine, where pharmacologic, surgical, or other specific treatment may be available; diagnosis and information-giving are the objectives of most genetic consultations. Genetic counseling is often provided in conjunction with a new diagnosis, with the goal of facilitating patient understanding and adaptation to the genetic diagnosis. However, evidence suggests patients and families may have difficulty in recalling and understanding the information they receive. For this reason, genetic counselors often provide families with a detailed letter summarizing the consultation. Although such letters are believed to be a vital and valuable communication tool in the genetic counseling process, little information is available on patient/family responses to these letters.

Methods: We conducted a case-control study to assess the effectiveness of two different genetic counseling letter formats. Parents of children receiving a new diagnosis were offered enrollment. The control group (n=85) received a letter in the traditional narrative format, 4-5 pages in length, with detailed explanations and medical terminology. After the control enrollment period, genetic counselors were trained by a professional medical writer to develop a concise letter format. The case group (n=64) received a concise letter, approximately 1.5 pages in length, utilizing lists/bullet points, lay terms, and simple sentences. Parents completed a survey 4 weeks after the visit to rate the letter’s format, usefulness, and their emotional reaction.

Results/Discussion: Results show that parents in the case group rated the letter more highly (p=0.023), particularly in the emotional response dimension (rating changes in anxiety, depression, fear, ability to cope, and confidence in response to the letter). Parents in the case group also rated the genetic counseling session more highly (p=0.039), though the counseling format provided to the two groups was not different. In the control group, parents without a college degree were more likely to rate the letter as too long and the level of medical detail as too high. In the case group, no significant differences were seen between parents with or without a college degree. These data suggest that a shorter, less medically complex genetic counseling summary letter is rated higher by parents, and is particularly associated with a more positive emotional reaction. The short letter format may ameliorate the effect of educational background on parental response to the letter.

Further study is needed to explore the effectiveness of genetic counseling summary letters. We propose that a short letter format highlighting the basic facts related to the genetic condition may be more useful to parents of diverse educational backgrounds, and may support a positive emotional adaptation at the time of a new diagnosis. Genetic counselors and other healthcare providers may benefit from specific training in medical and educational writing.

Emotional cue recognition in genetic counseling

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The importance of emotional cue recognition in medical communication has been firmly established (Roter & Hall, 2006; Henry et al., 2011). Several annotation systems tailored to doctor-patient interactions are available; however, perception-based coding of behavioral cues is labor-intensive, and in the vocal domain, unreliable (Kreiman & Sidtis, 2011). A number of (semi-)automatic techniques have become available in recent years; their advantage is that they are cost-effective and conducted at a fine temporal scale. We explored their use for the analysis of video-recordings collected in the context of genetic counselling for hereditary cancer at the University Medical Centre Utrecht, The Netherlands (Pieterse, 2005; Pieterse et al., 2007). For vocal analyses, a dataset consisting of 626 vocal fragments from 27 counselees and 14 counsellors was analyzed with Praat 5.3 (Boersma & Weenink, 2013). Since vocal pitch is an important source of information about speaker emotions (Justlin & Laukka, 2003), we extracted several pitch parameters (Mean, SD, Min, Max and Range), using the standard autocorrelation method (Boersma, 1993). Like sadness, expressions of anxiety/worry are typically presented with lower pitch (Goudbeek & Scherer, 2009) and in fact, in our dataset, lower pitch mean and max in counselees speech correlated with higher degrees of reported anxiety. We also found support for the view that for health care providers, listeners perceive lower pitch (and reduced rate) as more caring and sympathetic (McHenry et al., 2012): In the counselor vocal profiles, higher, more varied pitch correlated negatively with reported satisfaction with the counseling visit. In general, the results show that automatic analyses of vocal cues can be used to analyze and, potentially, improve medical interactions. For facial expressions, we are currently evaluating the success of several algorithms (CERT, Face Tracker, and FrameDifferencing Methods) designed to detect facial action units and/or basic emotions.
Risk communication using absolute risk reduction or prolongation of life format: cluster-randomized trial shows differences for primary preventive cholesterol-lowering medication acceptance

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Introduction/objectives: It is important that patients are well-informed about risks and benefits of treatments to help them decide whether to accept treatments. Different numerical formats can be used in risk communication. However, it remains unclear how the different formats affect decisions made by real-life patients.

The objective of this clinical trial was to assess the effect of using prolongation of life (POL) versus absolute risk reduction (ARR) to express effectiveness of cholesterol-lowering treatment on patients’ redemptions of statin prescriptions, and on patients’ confidence in their decision and satisfaction with the risk communication.

Methods: Fifty-six general practitioners (GPs) from 30 practices in Southern Denmark participated in a primary care-based clinical trial. GPs were cluster-randomised (treating practices as clusters) to inform patients in planned health promotion consultations about cardiovascular disease (CVD) risk by either POL or ARR formats for the effectiveness of statin treatment. Patients’ redemption of statin prescriptions were obtained from a regional prescription database. The COMRADE questionnaire was used to measure patients’ confidence in their decision and satisfaction with the communication.

Results: Of the 240 patients included for analyses, 112 were allocated to POL-information and 128 to ARR. Patients redeeming a statin prescription totaled 6 (5.4%) when informed using POL and 32 (25%) when using ARR.

No statistically significant differences were found between the allocation groups regarding satisfaction with the communication or confidence in the decision.

Discussion/implications: Patients less often redeemed statin prescriptions when their GP communicated treatment effectiveness using POL compared to ARR, but the level of confidence in decision and satisfaction with communication did not differ between the allocation groups. The trial suggests that GPs should apply effectiveness information cautiously because two different formats of the same reality may result in quite different decisions.

Communication of Genomic Information in a virtual weight counseling encounter

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Introduction: Genetic and genomic information related to body weight and obesity may be integrated into health care encounters in the future. Previous research has shown that provision of genomic information can lead to negative, positive, but most often no effect on patient motivation for health-promoting behavior. Furthermore, genetics discussions can influence the interpersonal relationship between patient and provider. It is important to understand whether communication factors can influence and potentially optimize the effect of providing patients with genomic information on their behavioral motivation and on their relationships with physicians.

Methods: Two hundred overweight women were randomized to receive either genomic or behavioral information about weight etiology. This occurred during a weight counseling encounter with a virtual reality-based doctor who used either a supportive or a directive communication approach. Using a virtual reality-based doctor allowed for complete standardization between conditions. Participants filled out one questionnaire online prior to their visit, and one questionnaire following the virtual encounter.

Results: Analyses revealed an interaction effect for participant's weight loss motivation. Among those who received genomic information, motivation was higher when the virtual doctor used a directive communication style. Among those who received behavioral information, motivation was higher when a supportive style was used. Participants who received genomic information were less likely to believe that exercise was an effective strategy for weight loss; there were no differences in efficacy beliefs related to diet. Participants’ perception that the doctor stigmatized them due to their weight was lowest among those who received genomic information, and among those who interacted with a doctor who communicated using a supportive approach.

Discussion/implications: Each type of information, genomic and behavioral, has value for enhancing different outcomes of weight counseling. The approach through which this information is communicated can furthermore influence its motivational effectiveness.
Patient-Centerededness

Obstetrical Patient Centered Medical Home Project: Addressing Infant Morbidity & Mortality in Milwaukee

Authors:
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Introduction/Objectives: In Milwaukee, there is a significant health disparity between African American infants and infants of other ethnic backgrounds. According to the Wisconsin Department of Health Services, January 2010, infants born to African American women are 3 to 4 times more likely to die before their first birthday than infants born to Caucasians; with preterm birth and low birth weight being contributing factors. Our clinic provides care to women who live in the most at risk zip codes of Milwaukee. In an effort to improve the health of babies in our community we have developed a team based patient centered medical home approach to obstetrical care.

Methods: The program consists of prenatal care coordination, physician visits, participation in the “Stork’s Nest” program and monthly educational group visits. The group visits are innovative and designed to be an interactive discussion. The topics are led by physicians with our prenatal care coordinators, physician residents, our community based nurse and our community partners (the Zeta Phi Beta Sorority). Topics have included - smoking cessation, breast feeding, and shopping with the doctor. Attendance is voluntary and does not impact their traditional prenatal care with their physician.

Results: The women stated they would participate in this program again and prefer it over just traditional office visits. They enjoy the support that comes from sharing experiences and learning from each other. Although our study is small, our data analysis has shown a reduction in preterm births and the number of low birth weight infants.

Discussion/Implications: An Obstetrical focused Patient Centered Medical Home model for care can be successful in positively affecting birth outcomes. By using a team based approach, we can share medical information with our patients so they can make healthier decisions during their pregnancy which can impact their health and that of their baby’s.

Religion and spirituality in the clinical interaction: Clinician communication differences in the patient-centered approach

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Introduction: As medicine strives to become more patient-centered, researchers have conducted an increasing number of studies examining the role of religion/spirituality (R/S) in health communication. This study explored the differences in clinician’s patient-centered communication in response to patient inquiry or disclosure of personal beliefs. Two hypotheses were developed.

H1: Clinicians responding to patient-initiated religion/spirituality (R/S) inquiries will give more information than clinicians responding to patient-initiated R/S disclosures.

H2: When comparing inquiry and disclosure conditions, there will be a significant difference in the proportion of adaptive messages communicated by clinicians in response to patient-initiated R/S messages.

Methods: This study was a single-site, two condition (inquiry versus disclosure) quasi-experiment. Participant clinicians were recruited from a family medicine department at an East Coast community hospital (N=28). A traditional evaluative tool, objective structured clinical examination, was used to expose the participants to a conversation regarding R/S. Coders categorized clinician utterances into mutually exclusive categories of a previously validated verbal behavior coding scheme (Street & Millay, 2001).

Results: Results show that when a patient asks questions, as compared to disclosing information, about personal beliefs the clinician provides more information. However, when the patient asks questions, the clinician also communicates more control messages, less partnership-building messages, and less supportive-talk messages.

Discussion: The finding here that clinicians expressed fewer partnership-building and supportive-talk messages in the inquiry condition may be linked to a physician-centered perspective. Partnership building and supportive talk are essential elements of patient-centered communication as they allow for patient experiences, concerns, and perspectives and permit patients to express their goals of care, including symptoms, feelings, thoughts, and expectations. Particularly salient here is the adaptive communication difference even when controlling for clinician’s perceived concordance with the patient’s beliefs. These findings prompt further review of the role of question asking as it relates to patient-centered communication.

Are Physicians and Patients Really Trained Listeners? Demonstrating and Discussing Listening Skills Training for Medical Encounters

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         Justin Coran, University of Florida
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         Jesse Arnold, Virginia Tech

Recent research suggests that when healthcare providers listen to patients, it can result in more compliance, enhanced patient satisfaction, and physicians are less vulnerable to malpractice lawsuits. Conversely, research suggests physicians’ noting that patients need to actively listen during the medical interview for better health outcomes. The purpose of this paper is to address our research on physicians’ formal listening skills training, patient listening behaviors, and to suggest using different types of listening, memory techniques and deception detection cues to enhance listening during medical encounters. Our survey of randomly sampled practicing physicians across medical specialties in the state of Florida were asked about their level of training in regard to specific listening skills (including discriminative, comprehensive, critical, therapeutic, empathic, active, etc.). We found statistically significant correlations between listening training and gender of physician, age of physician, and physicians’ abilities to detect nonverbal and verbal deception cues of patients. Older physicians tended to have less formal listening training; female physicians had more formal listening training than male physicians, and physicians with more formal training in listening skills were better able to detect verbal and nonverbal lying and deception among patients. Additionally, physicians commented on the listening behaviors of their patients. They specifically cited that “patients do not actively listen to the whole message discussed by the physician” (82%). Different types of active listening require a variety of skill sets which include discriminative listening (listening to decode auditory and visual stimuli), critical listening (listening to comprehend and evaluate message), empathic listening (understanding the other’s point-of-view), therapeutic listening (diagnostic and negotiated listening in consultations), and comprehensive listening (listening to understand, remember, and retain, especially during interruptions). We will further discuss and demonstrate types of listening and skills useful for physicians and patients during medical encounters.

Professional and Lay Navigators Achieve Same Results by Different Means

Authors: Claudia Parvanta, University of the Sciences
         Erik Benau, University of the Sciences
         Lina Jandorf, Mt. Sinai School of Medicine

Introduction: Mt. Sinai Hospital conducted research to increase screening colonoscopy (SC) among low income African American patients living in East Harlem. The study randomized patients to professional navigators (BS trained health educators) or lay navigators (patients who recently completed SC and took part in a training program) to provide guidance and support. The primary outcome of SC completion was high (75%) and with little difference if the patient had interacted with a professional (80%) or a lay navigator (71.3%), (p=.178.) In what ways did lay and professional navigators perform their tasks differently?

Methods: Patients had been consented to record navigation calls for research. We listened to the recordings and used computer-aided qualitative analysis software (MaxQDA) to code the calls according to the design parameters of the original study. We used 22 codes to annotate 6 calls by lay navigators and 6 by professional navigators, for a total of approximately 600 recorded minutes.

Results: Based on our coding, lay navigators were the only ones to use role modeling and offer coping strategies for patients fearful of the exam. They also were the only ones to speak about the benefit to the African American community, and address mistrust of the medical establishment or doctors. Of note, they were more likely to work on a plan with the patient. As expected, the professional navigators were more likely to educate, but, surprisingly they also provided more empathy and used simpler terminology or explained terms more fully.

Discussion: Lay and professional navigators approached their tasks in different ways. Research is planned on a larger sample of calls that will incorporate grounded theory as well as this a priori coding scheme to identify elements of the navigation interaction associated most closely with completion of SC in this population.

Communication through Technology

Computer Use in Safety Net Primary and Specialty Encounters: Seeing It From Both Sides

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Introduction/objectives: Persons with limited health literacy and limited English proficiency experience communication with their clinicians, which may contribute to suboptimal health outcomes. Electronic health record systems (EHRs) are increasingly present in U.S. safety net encounters. Limited research suggests that EHR use may both facilitate and inhibit clinician-patient communication, but no studies have examined this in diverse safety-net settings.

Methods: We are conducting an observational study of EHR use at a large, urban, academically-affiliated U.S. public hospital that uses a basic EHR (test results, prescribing, referral, and charting). Eligible patients include English- or Spanish-speaking adults with rheumatoid arthritis, diabetes, or congestive heart failure who receive primary and subspecialty care at 5 hospital clinics. Eligible clinicians include physicians, nurse practitioners, and fellows or residents. Enrolled patients have video-recorded visits with their primary and specialty providers. Perceptions about clinician computer use are captured on post-visit patient interviews and clinician surveys. For this analysis,
we descriptively analyzed sample characteristics and post-visit interviews/surveys.

**Results:** We have collected data for 49 visits among 38 patients and 32 providers. Among patients, 58% were women; 61% Latino/Hispanic, 18% Black/African-American, 13% Asian/Pacific Islander, and 8% White/Caucasian; 39% have diabetes, 34% rheumatoid arthritis, and 26% congestive heart failure; 50% had limited health literacy; and 52% were Spanish-speaking. Among providers, 63% were women; 34% nurse practitioners; 31% practiced family medicine, 52% internal medicine, and 17% subspecialty care. Patients’ perceptions of provider computer use were as positive as or more positive than provider perceptions (Table 1).

<table>
<thead>
<tr>
<th>Perceptions of provider computer use</th>
<th>Provider</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of computer use in the room</td>
<td>Most of the time</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Half of the time</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>Little or no time</td>
<td>67%</td>
</tr>
<tr>
<td>Made talking with the other</td>
<td>Harder</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>Easier</td>
<td>34%</td>
</tr>
<tr>
<td></td>
<td>Neither</td>
<td>50%</td>
</tr>
<tr>
<td>Computer helped doctor know about all in medical care</td>
<td>97%</td>
<td>100%</td>
</tr>
<tr>
<td>Computer helped visit go more smoothly/less stressful</td>
<td>75%</td>
<td>94%</td>
</tr>
<tr>
<td>Computer helped provider remember patient’s concerns</td>
<td>75%</td>
<td>94%</td>
</tr>
<tr>
<td>Provider did not look at patient enough because of computer</td>
<td>22%</td>
<td>4%</td>
</tr>
<tr>
<td>Provider listened carefully because of computer</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Computer helped provider take better care of the patient</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Overall liked the way provider used the computer</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Discussion/Implications:** Although safety net patients perceive high amounts of computer use by their providers, they report predominantly positive views about that use. Future analyses and the abstract presentation will describe actual patterns of computer use and communication using the Roter Interaction Analysis System and assess differences in patterns by language and health literacy.

**Physician EMR use and its effects on patient-centered communication**

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**Background:** The computer with the electronic medical record (EMR) is an additional ‘interactant’ in the medical consultation. Clinicians engage patient and computer simultaneously or in alternation to provide medical care. Few studies have examined how physicians’ EMR use influences the extent to which they are patient-centered in their communication (PCC). We hypothesized that physicians spending more time engaging the computer during the consultation would have lower ratings of PCC.

**Methods:** Twenty-one physicians from Veterans’ clinics participated in the study. Six patients/physician were recruited. Physician EMR use was captured in real time via video of the interaction and video of the computer screen. After the visit, patients completed satisfaction measures. Trained coders, blind to hypotheses, viewed videos of the interactions and rated the physicians’ communication using a validated measure of PCC. Physicians were divided into two groups—heavy EMR users (> 50% of the time looking at computer) and moderate users (< 50% of time looking at computer).

**Results:** The final sample included 121 consultations. Although patients were marginally more satisfied (p < .09) with physicians who were moderate EMR users compared with heavy users, heavy EMR users were rated by coders as less patient-centered (P < .0009). In analyses controlling for other variables, coders’ ratings of physicians’ PCC strongly predicted patients’ satisfaction (p < .0001).

**Conclusion:** Heavy EMR users received lower observer ratings of PCC which in turn predicted less patient satisfaction. Because patient satisfaction was only marginally related to physician EMR use, some physicians appear to be more skilled at multitasking and can perform necessary EMR tasks as well as engage in patient-centered communication. The findings have important implications for future research and clinical training, particularly with respect to how the EMR can be managed in ways that do not interfere with patient-centered communication.

**Providing audiotaped clinical encounters to patients - what do we know? A scoping review**

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**Introduction:** Providing audiotaped clinical encounters to patients was suggested by Hugh Butt in 1977 as a “method for better physician-patient communication.” Although the use and impact of recorded encounters on patient outcomes has been investigated by numerous studies including randomized controlled trials, and generally reported as being helpful, it has not been implemented in clinical practice. Our aim was to evaluate, in a scoping review, whether the existing evidence supports the potential adoption of this intervention in routine clinical practice.

**Methods:** Literature databases were searched for studies examining the effect of providing consultation recordings to patients. Full articles of abstracts for which the inclusion criteria were judged to be either fully met or unclear were retrieved and reviewed by two reviewers. We examined the reported outcomes of each study, including information recall and understanding, patient and clinician perceptions, risks and benefits associated with recording.

**Results:** Out of 5,492 records identified during database searches, 86 were retrieved for full-text review, 33 studies (1980s to 2012) met the inclusion criteria. The overwhelming majority of these studies reported almost universal enthusiastic use of audiotapes by patients, as well as sharing the tapes with family members, friends, and healthcare providers. Major benefits identified by the studies included filling information gaps and enabling patients to process information, providing an exact record of the dialogue and better understanding of treatment options, risks and side effects. Despite
some risks associated with providing recorded consultations to patients, e.g. compromised patient confidentiality, the risks were not perceived as prohibitive.

**Conclusions:** This review indicates that providing a record of clinical encounters is highly valued by patients, it helps them understand clinical information, and supports their discussions with family and healthcare providers.

Further work is needed to explore why this practice has not been routinely adopted.

**Communication Training of Cancer Patients via Smartphones**

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**Introduction:** Communication difficulties are a major barrier to the effective management of fatigue, pain, and depression symptoms during chemotherapy treatment. The primary aim of this pilot study was to develop and assess the effects of a tailored patient communication intervention on symptom severity over time in breast cancer patients undergoing chemotherapy. Secondary aims included assessment of intervention effects on quality of life and communication self-efficacy, and evaluation of study feasibility and patient responses to study participation.

**Methods:** Participants (n = 23) completed symptom inventories once/week on a smartphone from the beginning to the end of chemotherapy treatment. Videos that taught patients how to effectively communicate symptom-related difficulties were viewed on the smartphone the day before treatment visits. In addition, clinicians were emailed graphs depicting patients’ symptom severity over time the day before treatment. A longitudinal random effects model assessed changes in symptom scores over time. Descriptive statistics assessed intervention effects on quality of life and communication self-efficacy, as well as study feasibility and patient survey data.

**Results:** Of those eligible, 83% agreed to participate. The majority of participants were White (87%), married (61%), and well-educated (61% > HS). Pain severity/interference and depression scores decreased and fatigue severity/interference scores remained relatively stable over time. Pre-post changes in pain severity (p=.08) and pain interference (p=.09) were marginally significant, while depression (p=.21), fatigue severity (p=.38) and fatigue interference (p=.78) scores were non-significant. Pre-post changes in quality of life subscales and communication self-efficacy scores were mixed. Patient responses to study participation were generally positive.

**Discussion:** The intervention indicated potential towards improving symptom management of conditions that are common, costly, and detrimental to the health of the breast cancer population. Use of cell phones as an intervention platform posed difficulties for some users, leading to sub-optimal feasibility. Large-scale research is needed.

**Use of mobile and internet technology among older adults**

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**Introduction:** Health information is readily available on the internet and internet-enabled mobile technologies. Numerous innovations using such technologies to promote health are prevalent, but the accessibility of internet-enabled technologies pertaining to healthcare is less common, especially among older adults and those with limited literacy. The objective of this study was to investigate internet and smartphone utilization among older adults.

**Methods:** As part of a longitudinal cohort study, 302 adults between ages 55-77 participated in two interviews which included health literacy and cognitive assessments (LitCog Study). During phase 2, participants reported technology utilization. Univariate analysis was completed on questions relating to mobile phone and internet usage. Bivariate relationships between literacy level and age, with internet and cellphone use were tested using Pearson Chi-Squares.

**Results:** Of the phase 2 participants to date, participants’ mean age was 66 years and 45% had limited health literacy. The majority of participants had access to cell phones (94%) and internet (91%). Of all respondents, 47% of participants had mobile phones with smartphone capabilities; however fewer patients with limited literacy skills reported this (adequate literacy 54% vs. limited literacy 39%, P<0.05). Among participants with a mobile phone, 35% use it for email and accessing the internet, 32% use it to download applications, with significant differences existing in utilization between literacy level and age group; such that people with limited literacy and 65+ use mobile email, internet, and applications less.

**Discussion:** As mobile/web health technological interventions are becoming more widespread, significant age and literacy disparities exist in the adoption of these communication modalities. While home internet access is prevalent, applications designed specifically for smartphones currently do not reach this population which may potentially exacerbate existing literacy disparities. However, mobile phone interventions with simplistic technology, such as SMS-text messaging may be viable options for older adults and those with limited health literacy.
Mother/Child Well-Being

“I was actually going to tell her I have been smoking weed”: Pregnant Patients’ Perspectives on Marijuana Use Disclosure to Their Obstetric Care Provider

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Objectives: To describe suggestion facilitators for marijuana screening communication from pregnant patients who did not disclose their use to their obstetric care provider.

Methods: As a part of a larger patient-provider obstetric communication study involving audio-recorded first obstetric visits, we performed individual semi-structured in-person interviews with pregnant women who did not disclose marijuana use to their obstetric care provider, but had positive urine drug tests. We asked the women to offer advice regarding types of communication that would facilitate their disclosure.

Results: Of the 343 patients participants, 93 (28.2%) had positive urine drug tests for marijuana; 41 (44%) had not disclosed this use to their obstetric provider during their first obstetric visit. Sixteen of these patients participated in a semi-structured interview. Participants’ most frequently suggested the following provider techniques to facilitate marijuana use disclosure: 1) use specific terminology and detailed questions when asking about substance use rather than using a general “do you use drugs?” question and asking when the patient may have last used/amount of use; 2) use a more personable style rather than simply asking intake questions; and 3) increase patient comfort by making eye contact, using social talk with patients, and slowing the pace of the communication.

Conclusion: Our patient participants categorized marijuana as different from other types of illicit drugs and did not want to risk stigmatization as a “drug user” by answering positively to a general drug screening question. They also suggested methods for providers to make their communication style more personable leading to increased patient comfort and decreased concern regarding stigma. They suggested that more personable provider communication styles would facilitate disclosure.

Practice Implications: Providers should ask specifically and separately about marijuana when assessing perinatal drug use and do so in a non-judgmental and rapport building manner to increase patient disclosure.

“Asthma, Depression, Problems with Your Heart or Lungs?”: How Obstetric Providers are Screening for Mental Health Issues in Prenatal Visits

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         Judy Chang, University of Pittsburgh
         Cynthia Holland, Magee Womens Hospital
         Jill A. Tarr, Magee Womens Hospital

Background: Mental health disorders frequently affect pregnant women and have potential serious side effects for the mother and her unborn child. However, mental illness is often undetected and untreated. Mental illness screening is recommended for all pregnant women. However, limited research exists on how frequently this topic is addressed, the method in which providers address this subject, or what patient and provider-related factors are associated with mental health assessment.

Objectives: To determine how and how often obstetric providers screen pregnant patients for mental health issues, and what patient and provider factors influence the occurrence of this screening during first obstetric visits. Patient factors included marital status, race/ethnicity, level of education, and yearly income; provider factors included provider type.

Methods: Patient and provider participants were recruited from a culturally diverse population attending visits in a large urban outpatient hospital-based clinic. First obstetric visit conversations between obstetric care providers and pregnant patients were audio recorded and transcribed verbatim. Transcripts were then coded and analyzed for factors related to mental health screening.

Results: Among 103 audio-recorded visits, providers asked about mental health in 43 visits (41.7%). Type of provider was significantly associated with whether he/she asked the patient about mental health with nurse midwives most likely to ask (X2 = 28.8521, p = 0.000). Of the 43 patients who were asked about mental health, 36 (83.7%) were asked with specific terms (i.e. “Any depression, anxiety, bipolar disorder?” vs. “Any psychiatric problems?”) and 20 (46.5%) had the screening question grouped with an inquiry into various other health issues.

Conclusion: Providers frequently miss the opportunity to screen for mental illness during a patient’s first obstetric visit. Additionally, grouping the mental health screening with a variety of other questionings may increase the possibility the topic may be lost or forgotten among the other listed health issues.
Assessing Interpersonal Communication through an Ambulatory FOSCE in an OBGYN Residency Program

Author: Michele Manting, Texas Tech University Health Sciences Center

Introduction: There is increasing focus on competence in residency training in the United States. Interpersonal Communication, especially when combined with delivering sound evidence-based alternatives is a competence most often assumed based on test scores, patient satisfaction, and infrequent direct observation in non-standardized patient settings. Although a great deal of attention has been given to surgical skills, the same focus in the ambulatory setting has not been applied in an objective manner.

Description: A series of Formative Objective Standardized Clinical Encounters to assess communication skills and medical knowledge were designed to around common ambulatory presentations. Two cases required contraception counseling. Standardized Patients delivered the cases and OBGYN faculty evaluated them using both global and behavior-specific checklists. The results were shared with residents to facilitate personal professional growth.

Evaluation: In general, residents were friendly, helpful and professional and received positive feedback from the SP’s regarding global communication skills. However, regardless of level, there was a surprising lack of factual information conveyed with respect to a wide range of acceptable contraceptive methods. Emergency contraception was rarely mentioned despite being recommended for every reproductive-aged woman at annual visits. Additionally, no resident completed a sexual history that included both sexual orientation and practices.

Discussion: Communication skills have often been infrequently and indirectly assessed in the ambulatory setting. The Ambulatory FOSCE is a method that can help identify strengths and weaknesses before high stakes assessments. In this case, it is also possible to identify areas of weakness that might be surprising for the faculty involved. As a result, attention both in didactic, practice and other simulated experiences can assist in developing medical professionals who will both be able to communicate effectively not only in approachability but also in terms of positively impacting on patient outcomes.

Factors influencing acceptance of MMR vaccination: a survey among parents of adolescents in Italian-speaking Switzerland

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Objectives: Although public health offices have a detailed record of MMR vaccination coverage among adolescents in Switzerland, little is known about the factors predicting the parents’ decisions to get their children vaccinated. A health behavior model including predictors such as health knowledge, empowerment, communication behavior (both with healthcare professional and among peers), risk perception, attitudes, and beliefs about vaccination (Schulz & Nakamoto, 2012) was therefore applied to get insights in the role of each of these factors in explaining whether adolescents are not at all vaccinated, under-vaccinated or fully covered against MMR.

Methods: All families with adolescents attending the third year of middle school in Ticino (Italian-speaking Switzerland) were invited to take part in a survey including measures of all the concepts included in the behavioral model. Subsequently, survey responses were matched with actual data on MMR vaccination coverage of the adolescents collected from the Cantonal Office of Public Health in Ticino.

Results: A total of 603 parents took part to the survey. Preliminary results confirm the role played by several factors, including parents’ origin, communication behavior, beliefs, and perceived risk, in explaining the MMR coverage of their children and their general attitude towards vaccinations.

Discussion: The results of this study allow drawing more comprehensive conclusions about the factors that play a role in predicting parents’ decisions regarding the vaccination of their children. At the same time, the study provides useful insights on which are the main issues to be considered when addressing parents regarding the vaccination of their children both on an interpersonal as well as a mass communication level.

Keywords: MMR; adolescents; health knowledge; empowerment; health communication

“Breast or Bottle?”: Characteristics of Patient-Provider Breastfeeding Discussions at the Initial Prenatal Visit

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Introduction/Objectives: In recognition of prenatal care providers’ influence on infant feeding decisions, the American College of Obstetricians and Gynecologists (ACOG) recommends breastfeeding counseling commence at the first prenatal appointment and continue throughout pregnancy. Self-report data regarding frequency and content of such discussions are inconsistent. The purpose of this study was to describe the observed characteristics of breastfeeding discussions between obstetric care providers and their pregnant patients.

Methods: Audio and transcribed text from 172 initial prenatal visits at a single clinic (47 different providers) were reviewed for occurrence of breastfeeding discussions, timing and initiator of discussions, and adherence to a measurable subset of ACOG prenatal breastfeeding guidelines. Conversations were also qualitatively analyzed for breastfeeding-specific content and context.

Results: Breastfeeding discussions were infrequent (29% of visits), abbreviated (m=39 seconds), and largely a recitation of “benefits” by the provider rather than an open dialogue addressing patient con-
Breastfeeding was most often broached by providers (88% of conversations) during the breast exam (43% of conversations) in a manner that posited breastfeeding as a feeding preference rather than a health decision. Fewer than 20% of all visits incorporated any ACOG breastfeeding recommendations. Midwives were more likely than resident trainees to initiate breastfeeding discussions (p=0.03) and tended to engage patients in more open discussions. There was no significant difference in whether breastfeeding was actually discussed based on a patient’s infant feeding plans (p=0.46).

Discussion/Implications: Our data highlight the need to address provider and system-level barriers impacting subpar prenatal visit breastfeeding education. Further research is indicated to understand the impact of conversation content, style, and frequency on actual breastfeeding outcomes.

Shared Decision-Making

The call for rationality in shared-decision making

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Introduction: Shared decision-making is nowadays considered as a gold standard of doctor-patient communication. The literature on how to facilitate shared decision-making in the medical consultation is vast, but it tends to focus on the communication skills that doctors have to apply, while paying less attention to the skills that patients also have to have. The objective of this paper is to show that, for successful shared decision-making, patients have to act in critical discussion with doctors. And critical discussion, as the critical engagement with the interlocutors’ point of view, requires rationality.

Methods: The analysis is grounded in the literature on critical thinking and critical discussion from the humanistic tradition, and illustrated through real-life examples derived from a corpus of 25 medical consultations in the field of chronic pain, video-recorded in the Neurocenter of the Hospital of Lugano (Switzerland).

Results: The examples presented demonstrate the importance for patients to apply in shared decision-making three main categories of skills related to, first, the analysis of the point of view of doctors, second, its evaluation and, third, its confrontation with their own point of view. Moreover, the conduct of critical discussion presupposes the fulfillment of first-order conditions (i.e. avoiding unreasonableness) and of second-order conditions (in relation to psychological factors, including attitudes of speakers).

Discussion/Implications: Critical discussion calls for rationality, and this can be a challenge in the medical encounter given what is, often, its emotional nature. In light of this, this paper has main implications for the study of patients’ critical health literacy. By recalling an Aristotelian concept, critical discussion requires doctors’ and, moreover, patients’ phronesis, as the ability of acting “upon all things considered”. This paper gives indications on how to operationalize phronesis, as a starting point to develop interventions targeted to the enhancement of critical health literacy for shared decision-making.

Shared Decision Making in Daily Life Care: the development of a Digital Care Plan for long term care

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Introduction: In the Netherlands care plans are used in long term care to indicate the needs, preferences and goals of clients. It is usually not common for long term care residents to participate actively in their needs assessment. The introduction of so called “care level packages” (2009) by Dutch policy has increased the necessity for SDM in long term care. The aim of this study is to develop a tool, that is based on the internationally Care Dependency Scale (CDS, Dijkstra, 1998), to improve patient involvement in their care plan.

Methods: A multiple step design-approach was used to combine different forms of qualitative research. First, software-engineers took an internship on several nursing home departments. They learned how (paper) care plans are used during the day and what possibilities there are to improve shared decision making. Second, health care professionals were invited to develop the application in co-creation with engineers. Pilot versions of the application were tested in two nursing homes: researchers observed and interviewed care profes-

ional (n=8) using the Technology Acceptance Model for long term care (TAM2, Yu, 2008). Finally, opinions of clients and family were collected in three focus group meetings with members of client boards (n=13) of three different nursing homes.

Results: The developmental process resulted in a digital care plan (Lable Care), to improve resident participation and shared decision making during needs assessments. The digital care plan contains several elements. First, the CDS is chosen as central instrument to fulfill the needs assessment. The interface of the CDS is made suitable for
Shared decision making by using icons, graphics and more information (screenshot 1) to support the resident in participating. Second, after choosing care dependency, activities in which health professionals can support can be individually chosen. Third, a bar shows whether the chosen care suits to their care level package. Fourth, a summary can be printed for the residents to give them notion of the decisions (screenshot 2).

**Implications:** Currently, the tool is being evaluated in different care settings. During the presentation the tool will be demonstrated.

**Screenshot 2:**

<table>
<thead>
<tr>
<th>Mr. R. Karant: Care plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dashboard</strong></td>
</tr>
<tr>
<td><strong>Care plan</strong></td>
</tr>
<tr>
<td><strong>Pressure ulcer</strong></td>
</tr>
<tr>
<td><strong>Supportive oral nursing</strong></td>
</tr>
<tr>
<td><strong>Assess if nutrition needs can be orally consumed</strong></td>
</tr>
<tr>
<td><strong>Eat &amp; Drinking</strong></td>
</tr>
<tr>
<td><strong>Paying attention to alcohol use</strong></td>
</tr>
</tbody>
</table>

Shared Decision-Making among Latinos with Diabetes

Authors:
- Monica Peek, The University of Chicago
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- Robert Sanchez, The University of Chicago
- Marshall Chin, The University of Chicago

**Background:** Prior research indicates that racial/ethnic minorities have lower quality communication with their physicians, including less shared decision-making, which may contribute to health disparities. Shared decision-making (SDM) is associated with better diabetes health outcomes, but little is known about SDM preferences and behaviors among Latinos with diabetes.

**Methods:** We utilized a cross-sectional study (n=978) of Latino and white diabetes patients receiving care at community health centers located throughout the Midwest and Central West regions of the United States. Chi-squared analyses and multivariable regression models were utilized to explore relationships between Latino ethnicity and patient self-reports of SDM preferences (using the Patient-Practitioner Orientation Scale) and SDM behaviors, as measured by patient initiated discussions in 6 areas of diabetes care management (using binary measure as a composite assessment of all 6 diabetes care measures).

**Results:** Thirty six percent of the sample were Latino and 64% were female. The mean age was 57 years, and 44% had a high school or less education. Fifty-four percent of the sample rated their health as ‘good’, ‘very good’ or ‘excellent.’ After adjusting for sociodemographic factors, health status, and patient/physician relationship measures, Latinos were less likely to report preferences for SDM in areas of Agenda Setting (adjusted OR: 0.33 [95% CI: 0.25, 0.44], Information-Sharing (adjusted OR: 0.41 [95% CI: 0.0, 0.56] and Decision-Making (adjusted OR: 0.70 [95%CI: 0.51, 0.96]). There were no statistical differences in SDM behaviors between Latinos and white patients.

**Conclusions:** In this study, we found evidence suggesting that Hispanics with diabetes prefer to play a more passive role than whites in the decision-making process, despite reporting similar rates of discussion initiation with their doctors. Future studies are warranted to explore this complex relationship, including an assessment of English fluency and acculturation.

**Patient perceptions of shared decision-making: Process or outcome?**

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**Introduction:** Shared decision-making (SDM) has been suggested as an optimal approach to health care decision-making. In a recent review, only patient reports of having participated in SDM - not observers’ or others’ perceptions of SDM - were associated with patient outcomes, including greater patient satisfaction, less decisional conflict, and medication adherence. However, little is known about what leads patients to label a decision as being shared. The aim of this qualitative study is to better understand how patients perceive SDM in the context of primary care.

**Methods:** In-depth, qualitative interviews were conducted with 21 patients who had recently attended a primary care appointment. Interviews were conducted via telephone, audio-recorded, and transcribed. Qualitative content analysis of the interview data is ongoing.

**Results:** Preliminary results indicate that when asked about a specific health-related decision made in the recent appointment, if a patient agreed with their physician’s recommendation, then the patient typically labeled this decision as “shared,” regardless of the actual content of the interaction. In this way, patient perceptions of SDM appear to be more about the outcome (i.e., agreement) than the decision-making process itself. However, when asked about the meaning of SDM in the abstract, patients describe an active process based on trust in which both patient and physician share information, listen to one another, respond to concerns, and make a decision in the patient’s best interest.

**Discussion:** When patients report they have participated in SDM, they may be referring to the fact that they agree with their physician’s recommendation, and not to the specific communication process. Thus, while patients value SDM and want to feel listened to and respected by their physician, every type of decision may not require a full SDM process as currently defined by academic standards to achieve the associated benefits as identified in the literature.
An observation-based measure of shared decision making: Observer OPTION 5 Item

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Introduction: Measuring shared decision making is a challenge, despite reasonable consensus about the core characteristics. There are a number of observational measures of shared decision making of which most widely used Observer OPTION 12 Item measure is used to assess audio- or video-recordings of clinical encounters. However, application of the measure over the last decade has revealed areas where improvement could be made. We have revised the existing OPTION 12 Item to achieve improved construct validity, reliability and increased efficiency.

Objective: To propose a revised shorter and more focused Observer OPTION measure of shared decision making.

Methods: We analyzed published shared decision making models in order to identify the core components of shared decision making. By using this conceptual framework, we combined our experience of using the Observer OPTION 12 Item measure since 2001 with data from a large observational study of clinical practice in Canada.

Results: Our conceptual framework for shared decision making was based on the identification of decision needs, the justification of deliberative work, followed by the core steps of information exchange, preference elicitation and preference integration. By excluding items in Observer OPTION 12 Item that were idealized, seldom observed, or not aligned to an agreed construct, we propose a revised Observer OPTION 5 Item.

Discussion: Although widely used, Observer OPTION 12 Item did not give sufficient attention to preference elicitation and integration, and included items that were not specific to a core construct of shared decision making. We have attempted to remedy these shortcomings by proposing a shorter, more focused measure.

Practice Implications: We hope that Observer OPTION 5 Item will be useful as both a research tool and a formative measure of clinical practice. However, it will require evaluation through empirical studies.

Patient Participation

Sex Talk During Adolescent Health Maintenance Visits

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Importance: Adolescents have many misconceptions about sexuality as well as high rates of sexually transmitted infections and unplanned pregnancies. Because of this, it is recommended that physicians spend confidential time with adolescents to discuss sexual development, behavior and risk reduction, yet little is known about how often occurs.

Objective: To identify the frequency and predictors of sex content in adolescent health maintenance visits.

Design: Observational study of audio-recorded conversations between adolescents and physicians for sex content during health maintenance visits.

Results: 253 adolescents and 49 physicians were audio recorded. Average adolescent age was 14.3 years old; 53% were female; 40% White and 47% Black. Most physicians were White (84%) and female (65%); average age was 40.9 years old. One-hundred sixty-five (65%) of all visits had some sex content. The average length of sex talk was 36 seconds (35% had no sex content, 30% talked 0:01-0:35 seconds, and 35% talked more than 0:35 seconds). Multinomial logistic regression, adjusted for clustering of patients within physicians, found that females OR = 1.94 (95% CI 1.16-3.23), confidentiality discussions OR = 4.15 (95% CI 2.50-6.91), longer overall visit OR = 1.06 (95% CI 1.02-1.10), and adolescent in the room alone OR = 10.11 (95% CI 5.32-19.20) were more likely to talk longer about sex. In regards to teen participation, teens made no utterances in 40% of health maintenance visits.

Conclusion and Relevance: Our study may be the first to examine audio-recorded sex talk between physicians and adolescents. We found that one-third of all teens had annual visits without any mention of sex and even when sex talk did occur, it was brief. Research needs to identify successful strategies physicians can use to engage adolescents in sexuality discussions to help promote healthy sexual development and decision making.
Unraveling speaking practices that exclude or marginalize adolescents in office visits with clinicians and parents

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Introduction/objectives: Immunization serves as an important preventive service for adolescents. Few studies examine the process of communication and decision making that occurs during clinician-adolescent/parent triad interactions during office visits. This analysis will: 1) examine the participation patterns when clinicians speak with adolescents and their parents about vaccines; and, 2) identify specific speaking practices found within associated decision making discourse.

Methods: As theoretical approaches, the rights and obligations of the Markedness Model and the speech acts associated with Positioning Theory are used to examine the speaking practices of this primary care triad and the potential consequences to vaccine offers, acceptance, hesitancy, and refusal. Framed within a larger study of adolescent vaccine delivery, this project uses discourse analysis based in linguistic pragmatics to identify the predominant speaking practices found in recorded/transcribed interactions from six practices. The participation patterns suggest how specific speech acts may result in the inclusion or the exclusion and marginalization of adolescents in office visits.

Results: This analysis codes transcripts and recordings from 40 triadic office visits and finds that those patterns associated with engagement, mutual participation, and shared decision making occur infrequently. Specific patterns of yes/no questions, brief directives, lecture sequences, minimal politeness practices, and interactional alignment predominate, regardless of the parents’ presence or absence in the room. Only when questions were open-ended or when vaccine information was contextualized in terms of parental questions could decision-making between parent and clinician take place. Adolescents occasionally voiced their fear of shots but were otherwise effectively silenced by talk, thus positioning parents as the participating partner with clinicians.

Discussion/implications: Particular best practices offer opportunity for interventions. Future study will examine how the involvement of adolescents may contribute to vaccine acceptance, hesitancy and refusal. Though clinicians can provide leadership, vaccine interactions may be more effective using strategies of shared decision making.

Engaging Patients to Improve Depression Care Quality in Diverse Primary Care Settings: RCT of Computer-based Targeted and Tailored Messaging

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Background: Depression is an important, costly, and undertreated problem worldwide. Encouraging patients to disclose depressive symptoms and accept treatment holds promise for improving initial depression care quality in primary care (PC) settings, where the majority of depressed patients are seen.

Study Question: Do targeted or tailored computer-based patient education programs: 1) increase the likelihood that PC patients with significant depressive symptoms will ask for information about depression; 2) increase the likelihood that they will receive “Components of Initial Depression Care” (CIDC) -- antidepressant medication, a mental health referral, or both; and 3) improve depression symptoms and health-related quality of life?

Methods: We created two computer-based patient education programs to encourage patients to speak with their primary care physicians about depressive symptoms: 1) a 3-minute, targeted Public Service Announcement (PSA) and 2) a 5-15 minute, tailored, Interactive Multimedia Computer Program (IMCP). 559 patients with significant depressive symptoms (Patient Health Questionnaire [PHQ] scores >=5) seen in diverse health care settings in 2 US cities were approached prior to a routine office visit and randomized to the PSA, the IMCP, or a control video on sleep hygiene. Patients were contacted by phone to assess outcomes at 12-weeks.

Results: Compared to control, those assigned to the PSA or IMCP were more likely to ask for depression-related information (adjusted probabilities 11%, 19%, and 20%, respectively; p<0.05). IMCP patients were more likely to receive CIDC (adjusted odds ratio 1.8, p=0.03). However, there were no differences in depression or health outcomes at 12-weeks (p>0.05).

Conclusions and Health Policy Implications: Both the targeted PSA and tailored IMCP successfully encouraged patients to request depression-related information during primary care visits. However, only the IMCP improved care delivery. The study provides proof of concept that tailored computer-based education can help patients become agents for improving the quality of their own care.
Teaching - Evaluation

The “Value-Added” of Actor-based Simulation to Teach Communication and Relational Skills: Perspectives of Interprofessional Learners and Faculty

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- Kristina Fancy, Childrens Hospital Boston
- Kelliann Coleman
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- Elaine Meyer, Institute for Professionalism and Ethical Practice, CHB

Background: Simulation is an increasingly used educational strategy, but understanding learner and faculty experiences with actor-based simulation is limited. We developed live enactments with professional actors to simulate difficult conversations, and assessed the efficacy of actor-based simulation to teach communication and relational skills.

Methods: Surveys of 192 interprofessional medical and surgical learners and all 33 teaching faculty. Descriptive statistics/fisher exact test and Glaser and Strauss grounded theory were used for quantitative and qualitative data analyses, respectively.

Results: Of all participants 191/192 (99.5%) learners and 31/33 (94%) faculty completed surveys. Learners included 23% physicians, 60% nurses, and 16% psychosocial professionals. The vast majority of participants found the clinical scenarios realistic (99%) and clinically useful (96%). Nearly all participants (98%) and faculty (96%) described the actors’ portrayal of the patient/family as realistic, and reported that the actors valuable to the learning (97% participants, 100% faculty). Compared to simulated conversations with actors, 81% of participants and 97% of faculty felt that role-play with another clinician would not have been as educationally valuable. Comparison between workshop attendees who participated directly in the simulation (47%) and those that observed the enactment (53%) showed no statistically significant differences in any of the above five outcome measures. Qualitative responses of learners and faculty about actor value yielded 5 central themes: Realism, Importance of Actor Feedback, The Actor’s Layperson Perspective, Depth of Emotion, and The Role of Improvisation in Education.

Discussion/Implications: Improvisation and unscripted interactions mirror real practice, and are central aspects of “value added” to the actor-based simulation pedagogy. Direct feedback from actors, and providing patient/ family perspectives were key pedagogical components. The value attributed to actors after the educational experience was nearly universal among faculty and interprofessional learners (97-100%), and independent of direct participation in the enactment, offering a promising strategy for teaching communication skills.

Authors: Robert Hulsman, Academic Medical Centre  
Jane Van der Vloodt, Academic Medical Centre

**Introduction:** Self-evaluation and peer-feedback are key elements in the development of consultation skills and professional behaviour. Self-monitoring and self-regulation are important responsibilities of medical professionals to preserve and improve the quality of care in clinical practice (Epstein et al. J Contin Educ Health Prof 2008). Video review of patient encounters an effective tool for skills learning (Hammoud et al. Adv Med Educ Pract 2012). VideoFragmentRating.com (VFR) is a web-based system for systematic review and assessment of clinical performance of clerks. Clerks upload video recordings in VFR and mark and annotate critical events on a timeline with green and red coloured time-stamps. Next, peers or physicians are invited for written feedback in VFR. In this study the use of VFR and characteristics and structure of the written self-evaluations and peer-feedback was analyzed.

**Methods:** Participants were 26 pre-clinical clerks (11 male and 15 female), grouped in pairs. All participants recorded a history taking consultation, uploaded in VFR. They were invited to mark and annotate four critical events and to provide peer-feedback in VFR. Afterwards they filled out an evaluation questionnaire.

**Results:** Characteristics: The participants marked on average 5.4 events; 2.3 positive (green) and 3.1 negative (red). Males marked more events (6.3) than females (4.8). The same pattern applies to the peer-feedback, whereas additional peer-feedback is more often positive than critical. Females used more characters than males, negative comments take more characters than positive comments.

Structure: Adequate comments mention four components: 1. behaviour; 2. motive or effect; 3. suggestion for improvement; 4. goal of the suggestion. All students evaluated the interface and usability of VFR very positively.

**Discussion:** VFR is an efficient and effective method for systematic observation of clinical performance of clerks. It facilitates self-evaluation and (peer-) feedback, promotes an active involvement of students in assessment, makes assessment criteria more transparent to students, and contributes to self-regulation skills.

Spiritual Generalist Training for Interprofessional Healthcare Practitioners

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Mary Robinson, Boston Children’s Hospital

**Objective:** Patients and families highly value practitioners who inquire about their religious and spiritual needs, and seek to incorporate these perspectives into healthcare decision-making and treatment. Yet, few training approaches exist to impart these skills to frontline practitioners. We examined the efficacy of innovative, simulation-based workshops to train interprofessional practitioners as spiritual generalists who were capable of screening for spiritual strengths, listening for spiritual language, recognizing spiritual distress, accessing spiritual resources, and generating referrals to chaplaincy.

**Method:** Interprofessional participants attended day-long experiential workshops incorporating didactic instruction, experiential exercises, group discussion, and realistic enactments with professional actors to educate providers about the role and requisite skills of spiritual generalists. Participants completed pre-post workshop questionnaires using a 5-point Likert scale ranging from “Not at All Able” to “Highly Able.” Workshops are ongoing with a current sample of 93 interprofessional healthcare participants including physicians, nurses, social workers, psychologists, child life specialists, and medical interpreters.

**Results:** Immediately following the workshops, participants reported significantly greater perceived ability on all 15 assessed spiritual generalist skills including the ability to conduct spiritual screening, recognize spiritual distress, make referrals to chaplaincy, and document spiritual/religious issues relevant to healthcare in the medical record, among others. The mean score of the 15 spiritual generalist skill items significantly increased from 3.68 to 4.46 (t=-12.89, p<.001). Practitioners also reported that they planned to engage patients around spiritual topics significantly more frequently following the training workshops (Mean1=3.38, Mean2=4.41, t=-9.92, p<.001).

**Discussion:** Regardless of disciplinary affiliation, it is important that healthcare practitioners be adequately equipped to function as capable, confident spiritual generalists to recognize and meet patients’ and their families’ spiritual/religious needs. This innovative training demonstrates promising efficacy for training interprofessional healthcare practitioners with a skill set to function as spiritual generalists capable of conducting spiritual screening and incorporating spiritual/religious preferences into healthcare.
Empathy and gathering information improve during medical course: a cohort study

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Abstract: Effective communication is the corner stone to a fruitful patient-physician relationship. Teaching clinical communication has become a pivotal point in medical education realm. Approaches measuring the evolution of learned skills are needed since a decline in some communication skills has been reported during medical course. Two hundred fifty five undergraduate students, attending the second year, completed a 1.5 hours per week course during 4 months on basic communication skills. Final students’ evaluation consisted in an interview with a simulated patient, assessed by a teacher using a standardized framework. Three years later, while attending clerkships, 68 students of the same population completed a re-evaluation interview following the same procedure. Medical students, although presenting gender differences, maintained a communication skills mean level similar of post training evaluation at second year. However, significant differences in specific communication abilities were detected in this group of students suggesting that there is a balance between the competencies that improved, those that declined and those which remained unchanged. Empathic attitudes and ability to collect information improved, emphasizing the importance of patient contact on the applicability and maintenance of learned skills. On the other hand, interview structure, discussion with patient (impact of health problems, prior treatments and lifestyle strategies) and non-verbal students’ behavior showed a decline during clerkships. This could uncover the weight of context and professional influence, also reported by students. Present findings highlight the importance of communication skills training integrated throughout academic medical curricula.

Post-graduate communication skills training for medical specialists focused on patients with medically unexplained physical symptoms (MUPS)

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Objectives: Stepwise description of the development of a post-graduate communication skills training programme for medical specialists focused on patients with medically unexplained physical symptoms (MUPS) to improve specialist interaction with MUPS patients.

Methods: Using the ‘intervention mapping approach’ we accomplished a needs assessment (literature study and pilot) to formulate intervention objectives and identify methods and techniques for a MUPS-focused communication skills training programme for medical specialists.

Results: A 14-hour training programme which consists of experiential learning, role-play and feedback. Using skills from Cognitive Behavioural Therapy, medical specialists are stimulated to explore interrelating factors that reinforce symptoms, to reassure patients effectively and to provide plausible and understandable explanations for MUPS. Dealing with complex referrals and informing GPs properly are also practiced. Evaluation of the training programme (valuation of the skills and the programme, self-efficacy scores correlated with scores given by psychologists on their behaviour on the videotaped consultations) will be presented at the conference.

Conclusion: By applying the ‘intervention mapping approach’ we were able to create a feasible and promising intervention to improve specialist interaction with MUPS patients. Intervention effects are currently being assessed in a randomized controlled trial, in which 120 doctors will be trained and videotaped by the end of 2013. A total of 500 patients will be included.

Practice implications: If the RCT demonstrates sufficient effectiveness and efficiency of the MUPS-focused communication skills training programme, the intervention could be embedded in post-graduate education of medical specialists and residents.

Patients’ judgment skills in the concept of health literacy: first study results in 87 patients

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Abstract: The concept of health literacy has received increasing attention in recent years and the relationship between poor literacy and negative health outcomes is generally recognized. Yet, the concept has also been criticized. It has been argued to lack theoretical grounding and have only limited practical implications. Moreover, it has been said that solid measures are still missing. To address these issues, Schulz and Nakamoto (2013) have proposed to incorporate the notion of judgment skills into the concept of health literacy in order to capture patients’ decisions.

The aim of this research was to develop and validate a scenario-based measure for judgment skills, which aims to investigate patients decision-making related to the self-management of their disease. Sixteen scenarios were developed through literature review, focus groups with patients, and an online assisted Delphi study with doctors. In addition in-depth interviews with patients and medical practitioners were conducted. The scenarios reflected situations from patients’ daily life in which they have to take a decision that impacts their health condition.

To test the measure a survey with 87 primary insomnia patients was conducted. The sample was 61.2% female, between 25-73 years old (mean 50.79 years; SD 10.714), and participants suffered at an average of 10.67 years (SD 7.6). For the scenario-based judgment skills
A New Computer-Administered Measure of Health Literacy: Validity and Relation to Quality of Life in Spanish and English Speakers

Authors: Raymond Ownby, Nova Southeastern University
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Drenna Waldrop-Valverde

Introduction: Current measures of health literacy have been criticized for several limitations. We developed a new computer-administered and scored measure that assesses a range of health-related content and has well-defined psychometric properties for both Spanish and English speakers. The purpose of these analyses is to assess the validity of the new measure.

Methods: New test items were pilot tested in groups of Spanish and English speakers. Items were screened for equivalence in both languages and selected to provide a range of difficulties and content. The resulting 98 items are being administered to both Spanish and English speakers with a battery of other measures. Health literacy measures include the Test of Functional Health Literacy in Adults (TOFHLA). Quality of life is assessed with the Medical Outcomes Study SF-36. Preliminary scales of the new measure (general health literacy [HL], numeracy [NUM], listening [LIS], and conceptual knowledge [FACT]) have been developed based on item content and exploratory and confirmatory factor analyses.

Results: A total of 210 participants (103 Spanish, 107 English speaking; 116 Women, 94 Men, mean age = 51 years; range 19 to 84) have completed the new measure. For both Spanish and English speakers, correlations with existing measures of health literacy were similar (e.g., HL scale correlation with TOFHLA reading = 0.64, p < 0.001 for Spanish speakers and 0.61, p < 0.001; difference not significant, p = 0.73). The new measure’s HL subscale correlated with the physical and social functioning subscales of the SF-36 (e.g., 0.29, p = 0.005 for Spanish speakers).

Discussion: Results support the validity of the new computer-administered instrument as a measure of health literacy. It has significant relations with existing measures of health literacy and quality of life. An advantage of the new measure is automated administration and scoring, reducing demands on clinician time.

The Role of Abilities, Skills, and Knowledge in Health Literacy: The ASK Model

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Drenna Waldrop-Valverde

Introduction: Available health literacy measures have been criticized on a number of grounds. Our group has developed a new measure of health literacy that samples a wide range of health-related content and is useful in both Spanish and English. The purpose of this paper is to evaluate the extent to which cognitive abilities, academic skills, and health-related knowledge (ASK model) are related to performance on the measure.

Methods: The concurrent validity of the new measure had been previously tested. Its scales are significantly related to other measures, such as the Test of Functional Health Literacy in Adults (e.g., r = 0.64, p < 0.001). English-speaking participants completed the new measure as well as measures of crystallized and fluid cognition, academic skills, and health-related knowledge. A regression model was created with blocks of predictors entered sequentially: (1) age, education, gender, and race, (2) crystallized and fluid abilities, (3) academic reading skills, and (4) healthcare-related conceptual knowledge.

Results: Ninety-eight participants completed study measures. Each block of variables contributed significantly to the prediction of participants’ performance on the health literacy measure, with age (t = -5.62, p < 0.001), crystallized ability (t = 3.07, p = 0.003), academic reading skills (t = 3.78, p < 0.001), and healthcare knowledge (t = 5.60, p < 0.001) each predicting it in the final model. Each block of variables in the regression contributed significantly. The final model was associated with an R squared value of 0.73, suggesting that a large portion of the health literacy score was related to demographics and the elements of the model.

Discussion: Results of the study provide support for the ASK model of health literacy. Health literacy can be viewed as the unique combination of cognitive abilities, academic skills, and healthcare-related knowledge needed to obtain and use health information.
Validation of a Brief Diabetes Numeracy Test and Relationship to Diabetes Measures

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         Ken Wallston, Vanderbilt

Objectives: We previously demonstrated an association between a 43 item Diabetes Numeracy Test (DNT) and diabetes knowledge, self-care behaviors and glycemic control. Our objective was to validate a 5 item version of the DNT and examine its relationship with diabetes outcomes.

Methods: Using a historical sample of 398 diabetes patients, we performed psychometric analyses to reduce the DNT to 5 items. We then administered the DNT-5 to diabetes patients enrolling into a randomized trial to evaluate the efficacy of a health literacy intervention. Additional validated measures included health literacy/numeracy (s-TOFHLA, subjective literacy scale (SLS), Subjective Numeracy Scale (SNS)), patient characteristics, self-care behaviors (Summary of Diabetes Self Care Activities, and Personal Diabetes Questionnaire), and glycated hemoglobin (A1C).

Results: From July 2011 to March 2013, 401 diabetes patients were enrolled. Mean age was 51.0 (SD 9.5), 61% female, 63% White, 18% African American, and 24% Latino; 82% had a family annual income <$20,000 and mean education was 11 years (SD 7). Mean A1C was 9.6% (SD 2.1). Mean DNT-5 score was 46% (SD 37.5). Internal Reliability (KR-20) was 0.82. Higher DNT-5 score was significantly correlated (p<0.01) with higher SNS (r=0.34), SLS (r=0.34), s-TOFHLA (r=0.52), education level (r=0.43), income (r=0.17) and use of food labels (r=0.13). Paradoxically, higher DNT-5 score was correlated with less exercise (r=-0.17, p<0.001), poorer eating behaviors (r=-0.19, p<0.001) and higher BMI (r=0.16, p<0.01). In analyses adjusted for age, gender, race, ethnicity, income, and duration of diabetes, higher DNT-5 was associated with lower A1C (B=-0.65, p=0.05).

Discussion: The DNT-5 demonstrates excellent reliability and validity. A complex relationship between diabetes numeracy and self-care behaviors was identified which needs further exploration. As before, we found a correlation between numeracy and A1C, suggesting that diabetes numeracy may be an important target for future interventions to improve diabetes care.

PatientTIME; a computer tailored communication training for patients with malignant lymphoma

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Introduction: Effective patient-provider communication is essential for optimal cancer care. However, patients often experience difficulties with the communication and there is a distinct discrepancy between their preferred and actual role in consultations. This was the reason to develop PatientTIME; a computer-tailored communication training for patients with malignant lymphoma. The aim of the training is to support patients in the communication with health professionals. The project was initiated on patients’ request and they were involved in all steps of the iterative development following a context-mapping process of participatory design.

Description of the innovation: PatientTIME is a web-based intervention. Patients access the Internet program and experience how they can influence a consultation through short video clips of (simulated) consultations. The video clips center around communication elements, which they have indicated to experience as difficult (e.g. expressing concerns, asking for explanations). Additionally a Question Prompt Sheet is provided which can be used to indicate the most important questions and concerns patients intend to disclose to their medical specialist.

Evaluation: The intervention mapping framework helped to systematically apply theories, collect data and include empirical findings. Participating patients raised relevant topics and concerns during (group) interviews for which they also had prepared a booklet with assignments. This method enabled the researchers to include patients’ knowledge and experiences. Together with observations of real consultations at a hematology outpatient clinic, patients’ input was used for designing scripts for short video clips of simulated consultations, which form the basis of PatientTIME. Furthermore, usability tests were performed to find out if PatientTIME was used as intended.

Implications: How patients cope between follow-up visits partly depends on the information and support received during the visits. If patients with malignant lymphoma can be trained to get the most out of their follow-up consultations this might enhance their feelings of personal control.
Communication Through Technology

Patient and Physician Satisfaction With an Electronic Medical Record (EMR): Correlations With Computer Activity

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Background: Some have expressed concerns about EMR systems: increased workload for physicians, and problems with patient-physician interaction. The data reported here look at correlations between actual computer use by physicians during the patient-physician interaction and the satisfaction of patients and physicians.

Methods: General internal medicine physicians in VAMC continuity practices in one West Coast city were participants in this study. Each physician identified up to 6 patients to participate. Physician use of the computer and the patient-physician interaction were captured in real time via videotape of the interaction, videotape of the computer screen, and with the Morae system that records physician clicks and scrolls on the computer. Physicians and patients completed satisfaction surveys. Spearman correlation coefficients were used to analyze the correlations between patient satisfaction with the physician, and the amount of physician time spent viewing the computer; and for the correlations between physician satisfaction with the EMR and various computer activities.

Results: 23 physicians and 126 patients participated. The total time spent using the EMR negatively correlated with patient satisfaction of the interactional skills of the physician (p = 0.05). The total number of clicks and scrolls using the EMR negatively correlated with physician satisfaction including adequacy of data collection (p = 0.0024), use of time in the interaction (p = 0.0017), physician-patient relationship (p = 0.0368), and the cooperative nature of the patient (p = 0.0317).

Conclusion: Patient satisfaction with the physicians’ interactional skills, and physicians’ satisfaction of the clinical interaction were negatively correlated with increased physician use of the EMR. EMR systems need to be designed in a more physician friendly manner. Physicians should be coached about how to expedite their use of the EMR during the clinical visit as well as outside of the exam room in order to improve both theirs and their patients’ satisfaction.

Patient engagement for chronic disease management via online visits

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Introduction: Chronic disease management takes up the bulk of a primary care clinician’s time, and many chronic diseases have a behavioral component that is difficult to address via traditional face to face care. The ability to engage patients in their care has been one of the promises of telehealth, but this has been difficult to realize due to clinician adoption challenges. The prevailing model has been a consumer directed model, where the consumer connects with the provider electronically with a problem. We decided to attempt an alternative model, where the patient is engaged by the clinician after a face to face visit for a chronic condition.

Methods: We performed a one shot case study to examine the efficiency, and satisfaction virtual patient follow up visits using asynchronous online patient to physician exchange, and synchronous communication via phone/video between a patient and physician. Specific aims included 1) To examine the adoption and usage of the virtual follow-up website, 2) To examine patient and physician satisfaction with the conducting follow up visits virtually over The Web, 3) to gauge patient engagement in chronic disease management outside of the traditional office visit.

Results: Patients were very satisfied with the overall quality of the follow up visit for their condition, and were especially satisfied with the clinical skill of the physician despite not being physically examined. Patients were willing to spend 9 minutes to report objective and subjective data regarding their chronic condition. Clinicians were very satisfied with the evaluation and management capabilities of these visits, and felt they could replace in person follow up visits.

Discussion: Provider initiated e-visits in patients with chronic disease provide useful alternative to follow up in person visits. Patients were willing to use this modality as an acceptable alternative to an office visit, and were willing to take the time to report their current symptomatology and status. If scaled, this approach can engage chronic disease patients to consider their health outside of the traditional office visit, and could help improve access to primary care while reducing the cost of care for patients with chronic disease.

Designing mHealth Communication Tools for Cancer Care: What patients need, what clinicians need, and what’s the difference?

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Introduction: The use of mobile health (mHealth) tools in clinical communication settings affects both patients and healthcare providers. When designing tools to support communication, it is imperative to consider the needs of all stakeholders to prevent later issues. As part of our development of an mHealth tool for patientprovider communication in cancer diagnosis meetings, we conducted interviews and workshops with oncologist and patient stakeholders to determine the most relevant topics to each party.

Methods: We interviewed three oncologists from a local clinic regarding key ideas and concerns for newly diagnosed patient meetings, and to understand the discussion process. We then conducted three workshops with eight ovarian cancer patients to discuss ideas to improve and supplement initial diagnosis meetings for newly diagnosed patients. Audio was recorded, transcribed, and analyzed using content analysis techniques to pinpoint the most relevant topics to each group.
Results: For our two raters, we found good interreliability for both the oncologist interview data (Krippendorff’s α = .7042) and for the patient workshops (α = .658). The most recurrent topics to oncologists included: meeting patient needs, design considerations for tools for the exam room (including maintaining data, physical space, etc), and communication gaps (such as terminology). For patients, the most recurrent themes were: resource information provisions, information personalization, and customizable information constraints.

Discussion: We found conflicts in opinion between patient and oncologist ideas for augmenting communication. Specifically, oncologists suggested preparing patients for their discussions using videos or waiting room tablets. Patients, however, felt seeing this information prematurely could lead to misinterpretation. Oncologists also expressed interest in digital takehomes, whereas patients thought hardcopies were generally more accessible. Furthermore, patients suggested reminders for oncologists that emphasize that they are working with individuals in an emotionally sensitive setting. Methods for compromising these differences will need to be assessed in mHealth tool design.

Web based Personalized Feedback based on Acceptance and Commitment Therapy to Support Patients with Chronic Disease: The Development of an ACT coding scheme

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Background and aim: Recent developments in web-based interventions and related studies suggest the utility of these approaches. However, methods for analyzing content in web-based interventions are lacking, limiting the ability to evaluate intervention integrity, i.e. the connection between the intervention given and results achieved. To enhance the understanding of the therapeutic processes involved in such interventions we analyzed written personalized therapist feedback delivered via smartphones from two web-based Acceptance and Commitment Therapy (ACT) interventions delivered for persons with chronic widespread pain (CWP) and Diabetes Type 2. The aim of this study was: a) to develop a coding scheme consisting of codes describing how ACT and other possible therapeutic processes were working with individuals in an emotionally sensitive setting. Methods suggested reminders for oncologists that emphasize that they are working with individuals in an emotionally sensitive setting. Methods for compromising these differences will need to be assessed in mHealth tool design.

Results: The coded feedbacks reflected five of the six main ACT processes (values, committed action, mindfulness, acceptance and cognitive defusion) in addition to identification of communication and motivation strategies (behavioral support, advice, empathic statements, stimulate participation, creative communication, general and educational information). The degree of inter-rater reliability measured by Cohen’s kappa was 0.791.

Conclusions: The developed coding scheme can serve as a basis for coding written therapeutic feedback and for a thorough analysis of treatment integrity.

Cancer Communication

Communicating chemotherapy-induced side effects in medical oncology: Do patients mention side effects to their providers and how accurately is communication about side effects recalled by patients?

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Introduction: Patients undergoing chemotherapy are at risk for experiencing side effects that can lead to impaired quality of life. Although there has been progress in managing chemotherapy-induced side effects (CISE), little is known about whether and how patients and providers discuss management strategies for CISE.

Methods: Oncology visits before and after the first cycle of chemotherapy across 5 sites were recorded and coded. Inter-coder reliability ranged from kappa=0.82-0.91. Patients completed surveys about side effects discussed during their visits. Additionally, they completed a validated daily measure of CISE between the first cycle of chemotherapy and the following visit.

Results: Of 77 visits recorded with 30 patients undergoing emetogenic chemotherapy regimens, 53 were before the first cycle of chemotherapy and 24 were after the first cycle.

Patients accurately recalled whether CISE was discussed with their providers for 70.6% of the oncology visits and accurately recalled discussing management strategies for CISE for 84.6% of the visits. Patients accurately recalled whether they were provided with an opportunity to ask questions for 45.1% of visits.

Of the patients who reported experiencing moderate or severe fatigue, loss of appetite, and nausea and vomiting at least once after
Feasibility of a Team Approach for Discussing Prognosis and Treatment Goals (T-PAT) During Advanced Breast Cancer

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Context: A diagnosis of advanced cancer often requires patients to consider prognosis and end of life issues for the first time. Frequently, neither patients nor clinicians readily introduce or request discussions about prognostic information, treatment goals, or treatment preferences, often in the interest of preserving hope for cure. Consequently, patients are often sparsely informed about their prognosis and the goals of advanced cancer treatment, resulting in inaccurate patient expectations and greater downstream burden for oncologists and their staff.

Practice Innovation: We developed a team approach for discussing prognosis and treatment goals (T-PAT) that is designed to elicit patient’s preferences to tailor a prognosis and treatment goal discussion that is both realistic and hopeful. The intervention is currently being tested in a quasi-experimental design. This report of research in progress uses the RE-AIM feasibility framework to assess the T-PAT intervention among a sample of women with advanced breast cancer (n=60) seeking treatment at an academic medical center.

Evaluation: All aspects of the intervention will be described, including team roles, the development of scripts/training methods and study implementation. Intervention feasibility is assessed in terms of patient’s willingness to participate in each component, clinician delivery of required components, intervention timing, maintenance of the intervention over the study duration, and written reflections from patients and clinicians.

Implications: Feasibility and patient reported data contribute to scientific understanding and applied implementation of an effective prognosis discussion in advanced cancer clinical care. A team approach to prognosis discussion offers coordinated support to clinicians and patients facing a challenging clinical task. Increased patient understanding of prognosis and treatment goals during advanced cancer promises to reduce the burden of unmet patient expectations on clinical staff, and better prepare patients’ transitions to end of life care.

A 3 Part Flow Model of Patient-Centered Communication for Addressing Cancer Patients’ Emotional Distress

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Introduction/Objective: From first diagnosis to treatment to survivorship or end of life, people with cancer often experience considerable emotional distress. Emotional trauma, if unmitigated, not only
is a form of psychological morbidity, it can also contribute to poorer biopsychosocial and economic outcomes (Ryan et al., 2005). Though there has been extant on emotional distress literature, more research needs to focus on ways in which clinician communication can help patients cope with emotional distress across the cancer continuum. The purpose of this paper is to lay out pathways through which clinicians can more effectively respond to patients’ emotions in ways that contribute to betterment of the patient’s health and well-being.

Methods/Results: Upon reviewing emotional distress in cancer care literature, this paper analyzes emotional distress experienced by cancer patients and its potential deleterious effects on health outcomes in order to create and present a three part flow model to assist clinicians in better addressing the challenges of recognizing, exploring, and managing patients’ emotional distress in the clinical encounter. To enhance and enact recognition of patients’ emotions, clinicians can engage in mindfulness, self-situational awareness, active listening, and facilitative communication. To enact exploration, clinicians can acknowledge and validate emotions and provide empathy. Finally, to perform therapeutic value, clinicians can provide information, identify resources, and give a referral based on displayed emotional distress in order to produce positive, health outcomes.

Discussion/Implications: We conclude by discussing implications for research, clinical practice, and medical education. First, because communication serves different purposes, our model provides a way for researchers to target specific communication elements within each part. Second, the model fleshes out the ACGME’s competency “Interpersonal and Communication Skills” in specific ways to enhance clinicians’ skills. Finally, our model speaks to improving communication training for clinicians, especially as it relates to therapeutic action.

Emotional Storm Tracking: Toward the Development of a Method for Measuring Paralinguistic Expression of Emotions

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Recently, we have contributed several studies examining emotions in medical encounters. Over time we have refined our coding methods to ensure we distinguish between emotions that are attributed to providers and patients or their families. We have moved from a language-based coding system for empathic opportunities to a more nuanced analysis of types and severity of emotions. In examining emotionally charged conversations, we have encountered an intriguing problem: though there are moments when distress is quite high, the coding system we use to capture emotions often fails to detect these moments because linguistic cues are frequently indirect.

The problem stems from how we are foraging through these conversations. Our system is designed to give feedback to providers on how they respond to emotions; accordingly we had designed a system where only obvious emotions are tagged. This is done for two reasons: (1) validity and (2) reliability. Regarding validity, linguistic markers are often necessary to quantify emotional moments. Regarding reliability, getting multiple individuals to identify and tag mo-
ments of indirect speech (regardless of the topic of discussion) can be a challenge.

What most emotion coding systems universally lack, regardless of the method used for reviewing, is the ability to measure paralinguistics (i.e., speech intonation and rhythm) objectively.

This presentation aims to provide two useful and promising solutions to measuring paralinguistic features of conversations: Western music notation (Example 1) and a visual representation of MIDI (Musical Instrument Digital Interface) data (Example 2). The presentation will walk researchers through the problem of capturing the expression of emotion and illustrate how paralinguistics can be transcribed using these techniques. In our presentation we will use real life examples of emotional expressions to illustrate the output using both techniques (in this abstract we include an visual example of both techniques).

Example Western Music Notation

![Example Western Music Notation]

Example MIDI Output

![Example MIDI Output]

Healing Relationships Skills and Attributes Survey: An Instrument Development Study

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Introduction: Healing occurs in the context of a relationship. There is limited research on healing relationships in part because clinician skills and attributes needed to develop these relationships have not been quantified.

Methods: Data derived through an integrative review of the literature were used to develop the Healing Relationships Skills and Attributes Survey (HRSAS) submitted to an expert panel review (S-CVI = .94) and then completed by 546 clinicians from four health care organizations. The validity of the instrument was assessed using exploratory factor analysis, a concurrent survey, and discriminatory analysis. Reliability was estimated using Cronbach’s alpha coefficient (α = .95).

Results: The survey data produced three factors; Emotional Connection (α = .89); Knowing (α = .88); and Partnership (α = .87), accounting for 49.8% of variance in the data. Factor structure stability was demonstrated across groups as well as positive correlation with the Caring Abilities Index (r = .518). The instrument discriminated between theoretically diverse groups. The main effects of years of experience (Pillai’s Trace = .042, F = (6, 926) = 3.345, p = .003, η² = 0.021) on the HRSAS scores was significant. Post Hoc ANOVA results indicated that all three HRSAS subscale scores—Emotional Connection (F (2,464) = 6.84, p < .001, η² = 0.029), Partnership (F (2,464) = 4.78, p < .01, η² = 0.020), and Knowing (F (2,464) = 7.02, p < .001, η² = 0.029)—differed significantly by years of experience.

Discussion: The results of this study support the reliability and validity of the HRSAS and its use as an online survey tool. Further testing of this tool in multiple settings and populations will add to the body of knowledge regarding healing relationships and the quantification of skills and attributes needed to develop these relationships.

Room for patients’ worries: patients expressing concerns and GPs’ responses during general practice consultations about psychosocial problems between 1977 and 2008

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Introduction and objectives: During the past decades, we see a shift from a personal approach by GPs towards general practice care that is structured by clinical guidelines and influenced by organizational aspects, e.g. GPs working more often part-time. Moreover, patients have become more informed before entering the consultation room. We examined whether these changes may have influenced how patients share their concerns during consultations involving psychosocial problems, and how GPs respond to these worries.

Methods: Consultations videotaped between 1977 and 2008 and assessed by GPs as ‘completely psychosocial’ (N=512) were selected.

Proceedings From 2013 ICCH
and divided into three symptom groups: psychological symptoms, social symptoms and medically unexplained physical symptoms. Cues and concerns by patients and responses by GPs were coded with the VR-CODES system. Using multilevel Poisson models, we estimated frequencies on communication categories for two periods (1977-1989 versus 1995-2008) and compared these estimates.

Results: In 92% of the consultations, patients presented at least one cue or concern. Patients more often expressed indirect cues, compared to explicit concerns. GPs’ responses were mostly characterized by giving space in a non-explicit way (silence or back channels). Consultations involving psychological symptoms showed more cues and concerns by patients and more non-explicit responses by GPs (both providing and reducing space) in 1995-2008 compared to 1977-1989. Regarding social symptoms and medically unexplained physical symptoms, no significant changes over time were found.

Discussion and implications: Remarkably, patients seem to have become more expressive in sharing their worries during recent consultations involving psychological symptoms, while GPs respond more often in non-explicit ways. Possibly, patients experience less taboo on psychological problems. Although GPs provide facilitating behavior in response to expressed worries, they rarely explicitly support patients by showing empathy. We argue that GPs may benefit from more extensive training regarding empathy and explicit ways to support patients.

Keywords: doctor-patient communication; general practice; cues and concerns; psychosocial problems

Empathy in the Doctor-Patient Communication: A study conducted at the Primary Care Level

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Introduction: Empathy is defined as the person’s capacity to place herself in the other’s situation, to imagine how he/she feels and then communicate it. A good level of empathy has been associated with better doctor patient relationship and has been suggested to indirectly improve medical results. This study examined empathy in primary care centers in the South-West Area, Metropolitan Region of Santiago Chile.

Methods: In order to examine empathy in the doctor-patient communication in primary health care, recordings of 101 medical consultations were codified, using the method called Empathic Communication Coding System (ECCS). This coding system allows us to examine Empathic Opportunities (EO) that the patient provides, i.e.: moments during which he or she expresses an emotion explicitly or describes a significant situation that has occurred in her/his life, and the level of empathy the doctor achieved in reply to these EOs.

Results: 27.72% of patients provided at least one EO to the doctor, significantly more frequent among females and directly proportional to the length of consultation. If the length of consultation is higher than 6 minutes, the probability of having EOs is 89.3%, and for those consultations who lasts less than 6 minutes, the probability is 10.7%. 14.6% of the answers have an optimal level of empathy, 43.7% are suboptimal and 41.7% are no empathic responses.

Discussion: Most doctors included in the study did not provide with an empathic response to the empathic opportunities. We also found that time was a key factor in this outcome. The discussion focuses on the influence of these results on patient provider communication and how medical interviews are organized.

Health Systems and Interprofessional Communication

The organizational context of patient-physician interaction: hospital structures and working conditions

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Introduction: Particularly for cancer patients, the relationship to their treating physicians is important for coping with disease and treatment. Research has found associations between hospital structures and quality of care. Moreover, there is evidence concerning the link between physicians’ working conditions and their health and performance, yet it remains unclear whether the hospital’s work environment can also affect patient-physician interaction. Our aim is to investigate associations between the hospital work environment and breast cancer patients’ perceptions of trust in physicians, support and empathetic provision of information by physicians.

Methods: Data from two cross-sectional surveys conducted in 2010 were analyzed within the WORG OUT project. Survey data from 1,844 newly-diagnosed breast cancer patients treated in 35 breast cancer center hospitals in the German state of North Rhine-Westphalia was combined with data from 348 physicians from the same hospitals. Patients’ trust in physicians and their perception of support and empathetic provision of information by physicians were studied in relation to hospital structures (e.g. case volume, teaching status, ownership) and working conditions as perceived by physicians (e.g. workload, job demands, permanent positions, part-time work, satisfaction with remuneration). Multi-level linear regression models were calculated, which controlled for patient characteristics.
Results: The main results are that patients’ perceptions of trust, support and empathetic provision of information by physicians are consistently negatively associated with the hospital’s average physician overtime hours and the hospital’s percentage of physicians working part-time. In public hospitals, as compared to non-profit hospitals, patients had less trust in their physicians.

Discussion: This study contributes to the discussion about organizational influences on patient-physician interaction by providing preliminary evidence of associations between the hospital work environment and patients’ perceptions of trust, support and empathetic provision of information by physicians. The organizational context of patient-physician interaction should increasingly be emphasized in health communication research.

The Patients’ Insights and Views Observing Teams (PIVOT) Survey Can Engage Patients in Team Assessment

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Introduction: Characteristics of good teamwork relate to the safety and quality of health care services, offering insights about areas for improvement. We developed the 16-item PIVOT survey to measure patients’ observations of the dynamics of their health care team. For this study, we conducted a field test of our patient survey in an Emergency Department (ED).

Methods: The field test of the PIVOT survey took place over 6 weeks at an urban, academic medical center. The survey included the 3-item Patient Perception Score and 1 health status item for comparison purposes. Research Assistants (RA) recruited participants among ED patients and caregivers after confirming plans for home discharge. Once each volunteer privately completed the PIVOT survey, RAs collected the survey and noted patient acuity level and length of stay.

Results: Participants (N=101) included 86 patients and 15 caregivers, 53 per cent female, and acuity fairly evenly distributed between levels 2, 3, and 4. Rasch analysis revealed evidence related to the survey’s test content, response processes, internal structure (Cronbach alpha = .87) and associations with other patient measures. Frequency of observed behaviors for 12 positively-worded items ranged from 2.54 - 4.16 on a 5 point scale. For example, ‘I heard team members use each others names’ versus ‘I felt there was good communication between team members’ averaged at 2.74 and 4.12 respectively. Of the 4 negatively-worded items, fewer patients reported observing the behavior (range of means 1.10 - 1.28; 1 being ‘not at all’). However, some problems were revealed, such as 18 replies that ‘team members talked in front of me as if I wasn’t there.’

Discussion/implications: During this field test the PIVOT survey performed well as a measure of the ED patient perspective. Further applications of the survey could yield information about model interactions or problematic issues reflected in health care teamwork processes.

Evaluating Patient-Centered Care Cultural Transformation and Innovations in the US Department of Veterans Affairs

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Innovation

Introduction/context: The US Department of Veterans Affairs (VA) has made patient-centered care (PCC) a priority. Led by the Office of Patient-Centered Care and Cultural Transformation (OPC&C&CT), the aim is to transform VA culture to one in which patient-centeredness is fundamental, featuring personalized, proactive, patient-driven approaches to care. We know little about how innovative initiatives currently underway contribute toward the realization of patient-centeredness from the perspective of patients, providers and the organization.

Description of policy or practice innovation: Initiatives that encompass a range of PCC innovations are currently being implemented at four VA facilities designated as Centers of Innovation in PCC. Initiatives include: altering the physical environment of care; integrating complementary alternative therapies; strengthening patient-provider communication through personal health planning processes; training staff in PCC; and using patient-facing technologies.

Evaluation/impact: We assembled an interdisciplinary team to collaborate with operational partners and evaluate the effects of these innovations. We identified key elements of PCC from the literature and from a model developed by OPC&C&CT and used the elements to guide our evaluation process. We are drawing on mixed-methods to 1) create an innovation inventory and implementation map to understand how initiatives contribute to PCC and identify key challenges and successes in implementation; 2) examine patient perceptions of patient-centeredness across different initiatives, including perceptions of communication and the effect on patient behaviors; 3) identify organizational factors affecting implementation of innovations; and 4) assess the extent to which patient-centered principles are reflected in secure patient-provider email exchanges.

Discussion/implications: Understanding the impact of innovations in PCC deployed throughout a complex healthcare system is challenging work. Our efforts are ongoing, and capitalize on the unique strengths of qualitative implementation evaluation strategies and established measures of PCC. Outcomes from this evaluation will inform the future of PCC and set a framework for evaluating PCC as the VA continues its quest to change its culture of care.
Collaborative Care: A new model of care for children with undiagnosed complex conditions

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Background: Communication between healthcare providers is critical to making diagnoses in children with undiagnosed medical conditions. We developed an innovative program called the Declan Donoghue Collaborative Care Program (DDCCP) to increase collaboration between healthcare providers in an effort to make diagnoses in children with undiagnosed complex conditions. DDCCP was developed in honor of Declan Donoghue who died of a rare medical condition that was undiagnosed before his death.

Objective: To describe the DDCCP model and characteristics of children served by DDCCP.

Method: The DDCCP serves children with undiagnosed complex conditions; and unresolved serious clinical problems. Complex condition is defined as a condition that needs care from ≥ 3 specialists. The DDCCP team develops a detailed clinical summary by medical records review, caregiver history and clinician input. Then, the DDCCP facilitates an interdisciplinary meeting of all providers involved in the care of the child. Additional specialists are invited if they are deemed to be important to the meeting. DDCCP develops and subsequently implements a plan of care.

Results: Over a 2-year period, DDCCP has served 17 children (14 for diagnosis and 3 for plan). There were 10 interdisciplinary conferences for 8 children. Of the 14 referred without a diagnosis, a diagnosis was made in 9. Two children remain undiagnosed after 1 year; but both have avoided repeated invasive procedures and have good symptom control after DDCCP involvement. One illustrative case was a 2.5-year-old child who presented with multiple symptoms, recurrent hospitalizations and received medical care from 7 specialties. His conference involved 23 providers from 13 different specialties. Most diagnoses that this child had were excluded during the conference. He was subsequently diagnosed as Munchausen Syndrome by Proxy.

Conclusions: A model of collaborative care of healthcare providers helps make diagnoses, exclude diagnoses, and implement a plan thereby reducing unnecessary medical care.

Competency in Integrated care across professional disciplines

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There is an increasing focus on the need for integrated health care. Good integrated care relies on interprofessional understanding. However, students frequently report that they have no or little interaction with students from other health professions.

Based on a strategic initiative from organisations involved in health care delivery, research and education in in Central Norway, educational activities where students from different professions meet was developed. The theme was “Competency in Integrated care across professional disciplines” and as a pilot it was conducted in one day.

A total of 600 3rd year students from medicine, nursing, social work, physiotherapy, occupational therapy and social education (welfare nursing) took part. They were divided into groups of 10 with every profession represented in each group. The main content of the day (7 hours) was group work with discussions based on a video of a patient experiencing transitions that were uncoordinated and presentations of each discipline by the students themselves. The plenaries lasted for 2.5 hours and had one lecture on integrated care, a session with question and answer and presentations by some students on what they would say to employees in the health care sector about integrated care and interprofessional collaboration. Finally, the students saw a video of the same patient as in the first video, but this time with transitions that were coordinated.

The students rated the day as very successful.

There is a very high need for time consuming coordination in carrying out a project involving students from many different professional educations.

Healthcare Professionals

Do We Like What We See in the Mirror? Reflections by 4th year Medical Students about Unresolved Patient Experiences

Authors: Elizabeth Ross, Duke University
Alison Clay, Duke University
Daniel Shapiro, Pennsylvania State University College of Medicine
Colleen Grochowski, Duke University
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Introduction: Reflective writing is growing in popularity as a tool to improve self-awareness for health professionals-in-training. Understanding that students completing medical school have often had experiences that are unsettling and even traumatizing, the Capstone course at the Duke University School of Medicine directs students, in the context of supportive small groups, to write a letter to a patient. The letters were never to be mailed; instead, the instructions asked students to write honestly and openly about an unresolved issue. The letters were collected, de-identified and analyzed for themes utilizing qualitative reviews. All letters were coded for themes. Reliability was established by repeated analysis of the letters by the authors. Many letters focused on issues in communication. A number of broad themes consistently emerged throughout the letter along with many interesting sub-themes. Broad themes include feeling bad for the patient, put off by the patient, bad about oneself, good about oneself, bad about the team or team member, good about team or team member, bad about medicine, good about patient and family, good about medicine, or having no feeling/insight. Subthemes will be finalized upon
completion of the study, but reviews have shown that the experiences of medical school education and the early exposures to patient care on the wards have deep impacts on students which may remain unresolved at graduation and likely inform their practices as they go forward.

Communicating Empathy and Sympathy: Similarities and Differences between Anglophone and Francophone Nurses

Authors:
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Introduction/objectives: Although nurses are highly-skilled medical practitioners, recent research has shown that they are not necessarily prepared to cope with the reality of bilingual or multilingual language use in hospitals and clinics (Isaacs, Laurier, Turner & Segalowitz, 2011). This reality often requires nurses to seek out training in a second language (L2). However, current L2 materials rarely focus on the language that is actually used by native speakers in health communication situations. The objective of this study was therefore to create L2 training corpora based on the language produced by English and French-speaking nurses in specific speech tasks. In particular, this presentation looks at one emotionally-charged speech task and reports on the methods and language (English and French) used by nurses for communicating empathy and sympathy.

Method: Both native-speaking nurses (15 French; 15 English) and actors/patients (4 French; 4 English) re-enacted a role-play where nurses were asked to provide support to a 56-year-old man who learned he would no longer walk after suffering a severe stroke. The role-play was filmed and then transcribed orthographically, generating a corpus of 25000 words. The corpus was coded for 8 proposed methods of transmitting empathy/sympathy in a healthcare context (Bylund & Makoul, 2005; Pudlinski, 2005). Frequency counts were then analyzed statistically to compare use of the methods within and across both English and French corpora.

Results: Results showed that validation, formulation of the gist of the trouble, naming other’s feelings and assessments were the four most frequent methods used to communicate empathy and/or sympathy in both French and English; however, the frequency of use of methods and message formulation differed significantly across languages.

Discussion: Discussed are the similarities and differences when communicating empathy/sympathy in English and French in healthcare settings and also the importance of reflecting such differences in L2 training materials for nurses.


The physician role and empathy - a qualitative study of third year medical students

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Context: Empathy is important to ensure the quality of the patient-physician relationship. In a recent review of empathy development, it was concluded that empathy declines during medical training, especially during the third year. Considering the complexity of the phenomenon of empathy, it is a paradox that empathy in medicine is mainly studied through quantitative approaches, primarily self-assessing questionnaires. There is sparse empirical research on what may influence a medical student’s empathy.

Objectives: In this study we explored medical students’ opinions of what may foster or inhibit empathy during medical school and how this is influenced by the initiation into the physician role.

Methods: This was a qualitative study of 11 medical students attending their third year of medical education. Semi-structured interviews were used to explore their opinions of empathy. Content Analysis was used to analyse the transcribed interviews.

Results: Five main themes regarding aspects of how the physician role may affect empathy were identified: (1) Becoming and being a professional; (2) Rules to uphold emotional distance; (3) Biomedical knowledge comes first; (4) Emotional Control; (5) Cynicism as a coping strategy. These themes may originate in the hidden curriculum and work to reinforce each other to create a greater distance between the physician and the patient with the possible outcome of decreased empathy towards patients.

Conclusion: The students participating in the present study seem to struggle with adapting to the physician role and the regulation of their emotions in patient encounters. Biomedical knowledge is an important part of their understanding of the physician role and it seems like they exaggerate the objective and distanced ideals in medicine. They use coping strategies such as developing feelings of cynicism or loss of humanism towards patients, which are considered part of the hidden curriculum or physician socialisation process.

A Quantum Leap: Mental Health Training for Residents

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Introduction/Objectives: Two-thirds of all behavioral health patients receive care solely from untrained physicians. We present an intensive behavioral health curriculum for residents (5-year HRSA grant). Prior RCTs show positive patient outcomes using the models taught. Overarching objective: graduating residents will be as skilled with mental problems as they are with medical problems. Curriculum Objectives: Following training, residents will demonstrate mastery of: 1) an evidence-based patient-centered interviewing model; 2) advanced patient-centered interactions, such as efficiency; 3) an evidence-based model of shared decision-making; 4) an evidence-based mental health treatment model for the management of common primary care mental health conditions; e.g., depression, drug/alcohol misuse/abuse, psychopharmacology; 5) personal awareness practice; 6) working as a team.

Methods: We integrate the curriculum into the standard medical residency curriculum for 39 residents, using 100 hours a year of mostly experiential training to teach the above objectives. In PGY-1, objectives 1-3 above are the focus of lectures and a full-time one-month rotation. In PGY-2/3, we address objectives 4-6, mostly training in a “Complex Patient Clinic” in residents’ usual outpatient setting for management of behavioral health problems. Five fellowship-trained primary care faculty and 2 psychiatry faculty train the residents.

Evaluation: Using a quasi-experimental design comparing trained residents to untrained controls in a similar residency, we will evaluate learning by residents at the start of PGY-1 and the end of PGY-3: a) blinded ratings of digitally recorded simulated patient interviews to assess patient-centered interviewing, shared-decision-making, and mental health care, b) knowledge and attitudes of self-efficacy for the objectives; c) extensive formative evaluation.

Discussion/Implications: With insufficient numbers of mental health professionals, non-psychiatrists must be trained. Not aiming to create psychiatrists, we outline a curriculum to create competence for most high prevalence mental health problems, also training residents in referral to mental health professionals.

Internist’s views of productive interactions with chronic ill patients

Authors: Nicolen MH Kromme, University Medical Centre Groningen
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Introduction/objectives: Productive interactions between chronic ill patients and physicians are a topic of increasing interest. These patients are often disappointed about the care they receive of physicians. Physicians on the other hand regularly experience ‘difficult’ patients. Chronic ill patients often have multiple medical problems as well as psycho-social problems. Internists are supposed to have the ability to integrate diverse aspects of the patient’s illness in a more general view. However, what their view is on productive interactions with their patients has not been explored yet.

Methods: The study is based on in-depth interviews with 20 interns, varying in age, experience and profession, working in an Internal Medicine Department of a University Hospital in the Netherlands. Transcriptions are coded and analyzed, using Atlas Ti software program.

Results/preliminary: Generally, internists view establishing and maintaining a real contact, a ‘click’, as an important feature of a productive interaction. Their expectations and responses to patients are influenced by the severity of the illness, expected complications, the patient’s life-expectancy and the possibility of resolving medically unexplained symptoms. Demanding patients, asking time and effort, involve the internist’s well-being as well as the boundaries of medicine. Different responses to these patients may be explained by the internist’s personal style or beliefs. Dealing with multi-morbidity is considered as inherent to the profession and not as a factor complicating the interaction, except in the case of patients with psychiatric problems.

Discussion/implications: The context (different patient categories) as well as personal differences explain differences in the internist’s views and expectations of productive interactions.

Strength: the study gives insight in unexpected aspects of the internists views of productive interactions.

Limitation: the context of a group of internists within one University Hospital restricts the generalization of the results.

Patient-Centeredness

Listening to patients’ voices: patient-centric diabetes management

Authors: Ulla Connor, Indiana University, School of Liberal Arts
Jennifer Wright, Indiana University, School of Liberal Arts

Background: Research in health care has examined a wide range of variables to better understand how patients follow the advice of medical professionals in managing their health. Despite extensive research on variables in healthcare communication regarding how patients follow medical recommendations in managing their health, the factors associated with predicting and enhancing adherence remain elusive (Dunbar, 1998). Recently, linguistic researchers have begun to give voice to patients, and many researchers have called for a more concentrated study of the patients’ perspective in the contexts of adherence and self-management (Dulman et al., 2008). By identifying linguistic indicators for three well-studied constructs in relation to adherence-control orientation (Wallston et al., 1978), agency (Bandura, 1970), and emotion (e.g., Petticrew et al., 2002) - our prior
Research addressed the need to connect extensive psychosocial constructs of adherence to a linguistic methodology focusing on patient talk.

**Objectives:** Develop a unique methodology to describe and evaluate the three psychosocial constructs by identifying relevant linguistic features for each construct, including semantic roles, metaphors, idioms, certain characterizations of the self, claims to knowledge or ignorance, intensity and stance of expression, and hedges.

**Methods:** The methodology was developed with data from 43 transcribed semi-structured in-depth interviews of patients with Type 2 diabetes that elicited patients’ stories. The results of the high interrater reliability-scored linguistic analysis showed demarcations of clearly identifiable coding of patient types. Applications of the final coding systems have shown efficacy in predicting and explaining adherence (Connor et al., 2012; Antón et al., 2012; Clark et al., 2012).

**Results and Implications:** The implications of the validated linguistic coding systems for research also suggest how healthcare professionals can better listen to and analyze patient talk regarding diabetes management in terms of their control orientation, agency, and emotion. Chancellor’s

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**Patient-centered communication strategies for patients with aphasia: Discrepancies between what physicians know and use and what patients want**

Authors:
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Marla Clayman

**Background:** One million people in the United States live with aphasia, a language disorder typically resulting from a stroke. In qualitative studies, persons with aphasia report encountering multiple communication barriers within medical encounters that impede patient-centered care. As a result, patients report feeling disrespected and excluded from communication.

**Methods:** 17 encounters with patients with aphasia were video-recorded. All encounters were previously scheduled encounters with community physicians and a caregiver was present. Following each encounter, physicians completed a brief questionnaire and the patient and caregiver participated in a video-elicitation interview.

**Results:** The mean visit length was 22.5 minutes. Types of physicians included: primary care, disability (rehabilitation physicians and neurologists), and other specialty physicians (e.g.: cardiologists and gastroenterologists). Almost all patients, caregivers and physicians reported that the following strategies encouraged effective communication during their video-recorded medical encounter: extra time for communication, physicians asking closed-ended questions, physicians reading the patient’s body language and the caregiver facilitating communication between the patient and physician. During the video recordings, strategies most frequently used by the physician included asking closed-ended questions and having the caregiver assist with communication.

The majority of patients and caregivers reported that patients would additionally benefit from physicians using gestures and writing down words or key phrases when speaking. In the questionnaires, less than a third of physicians listed these as effective strategies to use with any patient with aphasia. During the video-recorded encounter, only one physician used gestures, and no physicians wrote down information.

**Conclusions:** While physicians are aware of and did use some strategies to facilitate effective communication with patients with aphasia, almost none used additional key strategies reported by patients and caregivers. Interventions are needed to educate and train physicians to use a range of patient-centered communication strategies with patients with aphasia.

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**Weight bias in medical students and implications for patient-centered communication**

Authors:
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Michelle van Ryn, University of Minnesota
CHANGES Study Team, University of Minnesota

**Introduction/Objectives:** Obesity is strongly stigmatized; and there is evidence that obese patients experience stigma while seeking health care, and thus, are more likely to avoid follow-up and preventive care. There is evidence that health care providers hold explicit (consciously controlled) and implicit (automatic) biases against obese people, however, the impact of these attitudes on the medical encounter is not known. In this presentation, I will review hypothesized pathways whereby provider weight bias may influence patient-centered communication, present findings on implicit and explicit bias from a national survey of medical students, and introduce an on-going research project aimed at finding whether provider weight bias influences the quality and content of communication with obese patients.

**Methods:** In the Medical Student CHANGES study, a survey was administered over the internet to 4732 1st year medical students (81% of those contacted) from a stratified random sample of 49 U.S. medical schools. An implicit association test, feeling thermometers, and a validated anti-fat attitudes scale were used to assess implicit and explicit weight bias. The prevalence and severity of these biases will be presented relative to biases against other stigmatized groups found in previous studies of health care providers and in the CHANGES sample. I will also present the individual factors that predict variation in bias.

**Results:** Implicit weight bias was highly prevalent. On average, students exhibited more bias against obese people than most studies of health care providers have found against racial minorities. Unlike race bias, which is rarely explicitly expressed by health care providers, explicit weight bias was also prevalent.

**Discussion/Implications:** Based on evidence that explicit biases predict communication and decisions, and implicit bias predicts nonverbal behavior, these findings have important implication for quality of interpersonal and technical care. On-going research is aimed at determining what affect these biases have on the medical encounter.
Dimensions of patient-centeredness - a systematic review

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Background: In the last years, patient-centeredness has gained in importance. Several models exist that describe dimensions of patient-centeredness. However, they reveal a lack of conceptual clarity regarding the term “patient-centeredness”. This results in a heterogeneous use of the term, unclear measurement dimensions, inconsistent results regarding effectiveness/outcomes, and finally in difficulties to implement patient-centeredness into routine practice. The aim of this review was to identify the different dimensions of patient-centeredness described in the literature and to propose an integrative model of patient-centeredness based on these results.

Methods: The search strategy included a protocol driven search, combined with citation and reference tracking, as well as personal knowledge and contacting of experts. Titles and abstracts were screened independently by two researchers. Subsequently, full texts were independently assessed for eligibility by two team members, i.e., to determine whether they include a definition or model of patient-centeredness. All articles that include a definition of patient-centeredness were included in the review and subject to subsequent content analysis. In each article the given definition of patient-centeredness was coded independently by two researchers. Codes were discussed within the research team and condensed into an integrative model of patient-centeredness.

Results: 4707 records were identified through primary and secondary search, of which 713 were retained after screening of titles and abstracts. 419 articles (59%) contained a definition of patient-centeredness and were coded. 15 dimensions of patient-centeredness were identified, e.g., patient-centered communication skills, patient information, involvement in care. These dimensions can be used to form an integrative model of patient-centeredness.

Conclusions: The proposed integrative model of patient-centeredness provides a foundation for operationalizing the different dimensions of patient centeredness in future research. It can be used to identify gaps in the measurement of patient-centeredness and eventually develop new scales to fill those gaps and overcome struggles within the measurement of patient-centeredness.

Modeling patient-centered communication: Oncologist empathic communication and patient involvement in breast and colon cancer treatment decision-making

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Introduction: Empathic communication refers to messages clinicians use to respond to a patient’s needs and feelings. The feeling of mutual understanding and respect may enhance the patient’s readiness to participate in medical decision making.

Objective: It is expected that patients of oncologists who express empathy will be more communicatively involved in consultations and regret their treatment decisions less.

Methods: Seventy breast cancer and colon cancer patients completed questionnaires directly after the consultation and three months after the consultation. Path analysis was used to examine the relationships between patient demographics, patient-rated oncologist empathic communication, patient perceived involvement in treatment decision-making, and self-reported patient decision regret three months after treatment decision making.

Results: The model yielded a good fit to the data, chi-square (df=7) = 11.25; p = .13. Oncologists’ empathic communication was directly associated with lower patient decision regret, p < .01, (controlling for clustering by oncologist and patient background variables). However, patient reports of empathic communication were not associated with patient perceptions of involvement, p = .61. Thus, there was no evidence for mediation by patient involvement.

Discussion: Oncologists’ empathic communication has important effects on patients’ decision confidence. Contrary to the expectations, a climate of mutual understanding does not necessarily promote patient involvement. These findings, their implications, and directions for future research are discussed.
Ethical Issues

Medical Ethics and Health Communication: Global Lessons from Ethical Codes

Authors: Lisa Bradford, Michael McCauley, Medical College of Wisconsin

Introduction & Objective: Physicians around the world acknowledge the importance of providing ethical care to patients, and the delivery of high-quality ethical care depends on effective patient-provider communication. The purpose of this study was to explore how ethical guidelines for communication have been articulated in the ethics codes of national and international medical associations.

Methods: Data for this study come from published codes of medical ethics from 20 national and international medical associations representing countries in North and South America, Europe, Asia, and the Middle East. These data were analyzed for structural codes and thematic content with NVivo, a state-of-the-art ethnographic data management system.

Results: Guidance about patient-provider communication followed four themes, which hold that physicians should: (1) communicate clearly so that all patients can give informed consent for treatment options; (2) maintain confidentiality regarding private communications, except in special cases; (3) collaborate with patients and families in all phases of treatment, including disclosure of medical errors and personal biases that impact patient care; and (4) engage in responsible public communications - with other health professionals to ensure continuity of care, and with the media regarding medical developments and the advertising of physician services. Most of the 20 ethics codes included content from all four categories. But these documents differed from country-to-country in terms of comprehensiveness, urgency, specificity, and degree of patient-centered focus.

Discussion/Implications: Two primary implications emerge from this research. First, we believe that greater consideration should be given to including specific descriptions of ethical communication practices in codes of medical ethics. Second, we believe that better articulation of communication practices in ethics codes and coursework may lead to including specific descriptions of ethical communication practices in codes of medical ethics. Second, we believe that better articulation of communication practices in ethics codes and coursework may lead to including specific descriptions of ethical communication practices in codes of medical ethics.

DEVOLPMENT OF MEDICAL STUDENTS’ JUDGEMENT IN CLINICAL ETHICAL DECISIONS

Authors: Thorsten Langer, Ole Jung, Maren Bongartz, Martin Schnell

Introduction: Physicians are confronted with various situations in their daily routine that require ethical judgement. To integrate the ethical dimensions in a decision is a professional skill that needs to be learnt. However, teaching ethics must consider the process of “becoming a doctor” that involves numerous influences (e.g. hidden curriculum) that can only partly be controlled for. This study investigates the development of medical students’ judgement in the course of their academic studies at medical school.

Methods: The study sample (n=42) consisted of medical editorials and letters to the editor published 1998-2012. Data collection and analysis were guided by genre theory and social constructionist grounded theory. Sample texts were read in their entirety and coded for recurring and interesting concepts and generic elements that constituted informed decision-making. Codes were refined into categories through iterative analytic memoing and “situational mapping” - an exercise illustrating the elements of the situation of inquiry and their interrelationships. Results were written into an explanatory narrative and discussed within the context of the prevalence of CDMR and changing North American obstetric policy.

Results: My presentation will focus on one central theme emerging from analysis: respect for patient autonomy. Proponents of CDMR constructed patients as autonomous consumers managing their own reproductive choices, while critics argued that patient autonomy was circumscribed by medico-legal, financial, and sociocultural factors. Neither side of the debate explicates the features of informed decision-making that might support and enact patient autonomy. Early authors (1998-2004) were largely supportive of CDMR while those who published more recently (2004-2012) were critical of the subject, reflecting temporal changes in policy and practice guidelines.

Too Posh to Push? The Construction of “Caesarean Delivery on Maternal Request” in Medical Journal Editorials

Author: Sarah Munro, University of British Columbia

Introduction/objectives: In the late 1990s, amid concerns about rising caesarean rates, medical journal editorials and letters to the editor began to discuss the subject of “cesarean delivery on maternal request” (CDMR) - caesarean performed without medical indications at the mother’s request. I explore how authors persuaded the obstetric community to view the emerging concept of CDMR as a real phenomenon and as an appropriate/inappropriate mode of delivery.

Methods: The study sample (n=42) consisted of medical editorials and letters to the editor published 1998-2012. Data collection and analysis were guided by genre theory and social constructionist grounded theory. Sample texts were read in their entirety and coded for recurring and interesting concepts and generic elements that constituted informed decision-making. Codes were refined into categories through iterative analytic memoing and “situational mapping” - an exercise illustrating the elements of the situation of inquiry and their interrelationships. Results were written into an explanatory narrative and discussed within the context of the prevalence of CDMR and changing North American obstetric policy.

Results: Comparisons between the three points in time reveal a development of medical students’ ethical judgments: The answers in year 1 are characterized by an “existential view” on the situation. The patient’s fate is acknowledged and the loss of his “natural voice”...
Complex decisions in end of life: many communication roles for the ethicist

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Context: Performing clinical ethics consultations requires many skills, especially in communication. Depending on the nature of the problem, the ethicist can use various approaches in resolving complex ethical problems. The ethicist can also play different roles, but the boundaries are blurred. What are those communication roles, and how can they help or impede clinical ethics consultations? The objectives of this presentation are to explore, through a complex case in end of life, what are the contributions/pitfalls of different communication practices an ethicist can endorse within his work at the bedside.

Practice innovation: We will first expose a complex case: A man with 4 children from two previous marriages, and a new wife of one month, came to the emergency unit after a stroke. The bleeding led to brain haemorrhage and neurovegetative state. This man had been on dialysis for the last 10 years. Medical team suggested stopping all life sustaining treatments. Everybody agreed, except for the new wife who was claiming it was against her religious beliefs. The medical team called for an ethics consultation. 2- We will present the new wife who was claiming it was against her religious beliefs. The ethicist can be an educator, a mediator, an advocate for the patient, a whistleblower, a conflict resolver, a substitute for the medical team or the family, etc. In playing those roles, the ethicist can face pitfalls such as loosing distance, going too far in the clinical or family affairs, losing credibility, create bigger conflicts and misunderstandings. There is a need to better understand those roles, their boundaries in order to prevent bad consequences and articulate what are the best communication practices.

Impact and discussion: The ethicist can be an educator, a mediator, an advocate for the patient, a whistleblower, a conflict resolver, a substitute for the medical team or the family, etc. In playing those roles, the ethicist can face pitfalls such as loosing distance, going too far in the clinical or family affairs, losing credibility, create bigger conflicts and misunderstandings. There is a need to better understand those roles, their boundaries in order to prevent bad consequences and articulate what are the best communication practices.

Spirituality in home hospice care: Process and themes in nurse-family conversations

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Introduction/objectives: As increasing numbers of individuals choose to die in their homes supported by hospice, there is a growing need to ensure that hospice teams are addressing the spiritual and existential concerns of patients and families for the provision of quality palliative care. While there has been recent consensus on what quality spiritual care at end of life should include, there is a lack of research describing actual spiritual interactions in home hospice care. Our objective was to identify common themes of spiritual discussions to inform training and practice.

Methods: Nurse home hospice visits to consenting patient/caregiver dyads were audiotaped and transcribed. Using a definition of spiritual care created through national (U.S.) consensus, we used a deductive content analysis approach to analyze visit transcripts. Primary codes representing key concepts were applied to the data, identifying and categorizing spiritual/existential conversations.

Results: In total, 33 nurse home visits for 7 cases were audio-recorded by 5 hospice RNs (2-10 visits per case). There were 98 instances of spiritual-related talk over 22 visits (11 visits had no spiritual talk; all cases included spirituality in at least one visit). Six key themes were identified. Four strength-based: spiritual connection; dignity; religion; spiritual comfort and two themes reflecting spiritual distress: inner conflict; grief. Spiritual talk typically lasted one speaker turn, but ranged up to 40 turns. Nurses most frequently introduced a spiritual issue, but they were also most likely to change the subject.

Discussion/implications: Findings from this pilot project identify common dialogue patterns for spiritual talk as well as themes of spiritual strengths and concerns discussed in a home hospice nurse visits. This work provides a starting point for hospice care providers to 1) know what types of spiritual/existential conversations are likely to occur in hospice and, 2) areas for improvement in teaching and mentoring hospice clinicians.
Communication about Prescription versus Over-the-counter Analgesics in the Emergency Department

Authors:
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Introduction/Objectives: The chaotic and time-constrained nature of the emergency department (ED) limits opportunities for communication with patients about their new discharge medications. This study used the previously developed Medication Communication Index (MCI) to compare counseling about prescription (Rx) vs. over the counter (OTC) analgesics in the ED.

Methods: Audio-recordings of 41 complete ED patient visits for three diagnoses (ankle sprain, back pain, laceration) were independently analyzed by two coders using the MCI. The MCI is a maximum 5-point index that assigns points for communicating: medication name (1 point), purpose for taking medication (1 point), duration of use (1 point), adverse effects (1 point), number of tablets (0.5 point), and frequency of use (0.5 point). Additional data on patient demographics and visit characteristics were abstracted from the medical record.

Results: The 41 patients received 56 total prescriptions (27 for OTC analgesics and 29 for Rx analgesics). Half were male. Inter-coder reliability was high (Kappa = 0.90). The overall mean MCI score for OTC was 3.02 and for Rx was 4.05 (p=0.0005). Patients receiving OTC and Rx analgesic prescriptions were equally likely to be counseled about the medication name (OTC 100% vs Rx 96.6%, p=0.34), and purpose (OTC 88.9% vs Rx 89.7%, p=0.93). However, patients receiving Rx analgesics were more likely to be counseled about the duration of medication use (OTC 40.7% vs Rx 69.0%, p=0.03) and adverse effects (OTC 18.5% vs Rx 91.1%, p=0.001). In the multivariable model, prescription type (β=0.54, p=0.04), number of medications prescribed (β= -0.44, p=0.05) and amount of time spent in the ED room (β=0.008, p=0.005) were all significant predictors of total MCI score.

Conclusions: The extent of counseling about analgesic medications in the ED differs by drug class. Increased communication about duration of medication use and OTC adverse effects may improve patient understanding of medication instructions.

Communication about ADHD and its treatment during pediatric asthma visits

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Objectives: The objectives of the study were to examine provider-family communication about attention deficit disorder during pediatric asthma visits.

Methods: Children with asthma, aged 8 through 16 and their parents were recruited at five pediatric practices. All medical visits were audio-taped. Children were interviewed after the visits.

Results: 296 asthmatic children enrolled into the study and 67 of them also had ADHD. Boys in the sample were significantly more likely to have a diagnosis of ADHD. ADHD communication elements suggested by national guidelines were discussed infrequently: (a) target outcomes were discussed during one visit, (b) a treatment plan was established during only one visit, and (c) the provider explained that ADHD was a chronic condition during one visit. Teacher and school-based functioning issues were discussed during 35.8% of the visits, home functioning was discussed during 11.9% of the visits, and social and community functioning was discussed during 1.5% of the visits. Providers discussed ADHD medications during 37.3% of encounters. The ADHD medication areas that providers discussed most often during the medical visits: (a) generic versus brand medications (25.4%), (b) amount/dose (17.9%), (c) how well the medication is working/benefits (17.9%), (d) risks/side effects (16.4%). Adherence was only discussed during 3% of visits. Providers were more likely to discuss, educate, and ask one or more questions about ADHD medications if the visit was non-asthma related. Providers included child input into the ADHD treatment regimen during 3% of visits and they included parent input during 4.5% of visits. Only one child and three parents asked questions about ADHD.

Implications: Providers should make sure to communicate with families about ADHD and its treatment during visits and encourage families to ask questions so they can be more active participants in their care.

Interaction Process and Topic Domains in Clinical Encounters

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Objectives: Unidimensional systems for coding clinical communication, such as the Roter Interactional Analysis System, are used to operationalize patient-centered communication and other constructs related to patient satisfaction and health outcomes. Such systems do not consistently separate the distinct properties of topic and interaction process, and do not permit comparison of interaction among the various components of an encounter.
Using Thin Slices to Code Motivational Interviewing Counseling Sessions

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Introduction: Motivational Interviewing (MI) is an evidence-based clinical communication approach for increasing motivation for behavior change. Research examining how MI evokes behavior change requires resource-intensive coding of audio- or video-recorded MI sessions. Thin slice methodology may achieve the same goal with reduced coding burden, but demonstrates mixed utility within different contexts and has not been applied to MI. We compared the utility of thin slice methodology to characterize adolescent and counselor communication behavior during MI sessions.

Methods: Thirty-seven video-recorded MI sessions with African American adolescents with obesity and their weight loss counselors were transcribed and coded using the Minority Youth - Sequential Coding of Process Exchanges. From this coded data, four thin slice samples were selected by dividing the interaction into equal segments and extracting slices of coded data from the middle of each segment: (Sample #1) four one-minute slices, (Sample #2) six one-minute slices, (Sample #3) four two-minute slices, and (Sample #4) six two-minute slices. The frequency and correlation of behavior observed in each thin slice sample was compared to the full interaction.

Results: The proportion of each of the four adolescent communication behaviors varied at most 4.7% in the thin slice samples from the full sessions; counselor communication behavior varied less (≤3.0%). Variation decreased with a greater number (i.e., 6 versus 4) and “thicker” (i.e., 2-minute versus 1-minute) slices. Correlation between the thin slice samples and the full session increased across all but three counselor communication behaviors with more and “thicker” slices.

Discussion: Thin slices methodology may be a useful strategy to reduce coding burden using the MY-SCOPE when more and “thicker” slices of the interaction are sampled. This reduced burden increases the utility of the coding scheme; that is, with fewer resources needed for coding; the MY-SCOPE may be applied more widely used in a variety of contexts.
Behavior Change

Weight’s up? Predictors of weight-related communication in primary care visits with overweight adolescents

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Background: Little is known about how physicians talk with their overweight adolescent patients about weight-related issues. Guidelines recommend using Motivational Interviewing (MI) techniques. Physicians’ MI techniques might vary based on patient and physician factors.

Method: We coded audio-recorded encounters between 47 primary care physicians and 167 of their overweight adolescent patients, when they discussed weight. We used the Motivational Interviewing Treatment Integrity Scale to assess MI techniques. We coded behavior counts per encounter: open-ended questions, reflections, MI adherent behaviors (e.g., praising, giving advice with permission) and MI non-adherent behaviors (e.g., confronting, showing disapproval). We also coded global scores (5-point scale) of Empathy and MI Spirit (e.g., collaboration, evocation, and autonomy support). We examined associations between patient or physician characteristics and MI techniques. We used generalized multivariable linear models adjusting for patient clustering within physicians using p<.10 in these exploratory analyses.

Results: Adherence to MI techniques was moderate (mean (SD): MI Spirit 2.1(0.9); Empathy 2.5(1.0); MI adherent 1.6(2.4); MI non-adherent 3.1(3.7); reflections 0.0 (SD=0.4)). Physicians were more likely to use MI adherent techniques with female patients (p=.05) and with heavier patients (p=.03). Physicians who had prior MI training were more likely to use MI adherent techniques (p=.06) and ask open-ended questions (p=.03). Physicians who have been out of medical school longer used less open-ended questions (p=.04). Female physicians (p=.06) and those with higher BMIs (p=.08) were more likely to use MI non-adherent techniques. Physicians used more MI non-adherent techniques (p=.09) and asked less open-ended questions (p=.08) with patients whose mothers had lower education. Pediatricians had a higher MI Spirit score than family physicians (p=.03).

Discussion: Physicians, particularly female and family physicians, could improve their use of MI with overweight adolescents. Physicians seemed to vary in their MI techniques based on patient factors. Understanding why these differences exist should be a priority.

Exploring lifestyle counseling in routine primary care consultations; the professionals’ role

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Introduction/Objectives: It is generally acknowledged that general practitioners (GPs) and practice nurses (PNs) may significantly contribute to a patient’s healthy lifestyle behavior. Two counseling techniques are known to strengthen this process: tailoring information and advice about lifestyle behavior to a patient, and motivational interviewing (MI). It is not clear to what extent GPs and PNs actually apply these techniques during routine consultations. To examine how GPs and PNs discuss patients’ lifestyle behavior, in terms of the level of tailoring of information and advice, and their application of Motivational Interviewing.

Methods: We randomly videotaped GP-patient and PN-patient consultations within Dutch general practices and selected 124 and 141 consultations, respectively, that included any discussion about the patient’s lifestyle. These were analyzed, using the ‘Behaviour Change Counselling Index’ (BECCI), level of tailoring and content of lifestyle counseling.

Results: Information about lifestyle is mainly given in generic terms by GPs and PNs. In contrast, advice about smoking behavior more often seems to be tailored to the patient. GPs hardly ever applied MI in their consultations about patient’s lifestyle behavior. PNs trained in MI, did apply this technique, but also to some extent only.

Discussion: Both GPs and PNs somehow perform lifestyle counseling according to generally acknowledged criteria. However, for both, there is room for improvement in the application of MI skills and in tailoring of information and advice about lifestyle behavior. Effort needs to be put into integrating such techniques into busy daily practice while simultaneously complying with the many other clinical demands.

Needing More than a Pat on the Back: When Pregnant Women Want to Quit Smoking

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Objective: Screening for the use of tobacco products is a routine part of the first obstetric visit. Many women who smoke during pregnancy find it extremely difficult to quit and assistance from healthcare providers is not always offered. To better understand how obstetric providers respond when women express a desire to quit smoking, we
examined audio-recorded obstetric visits to describe providers’ advice and suggestions when assisting with smoking cessation.

Methods: We audio-recorded first obstetric visits of pregnant women who admitted to smoking cigarettes. These visits were coded for patient willingness to quit and providers’ responses to their desire for smoking cessation.

Results: Of the 74 audio-recorded visits with pregnant smokers, 47 women (64%) expressed an interest in quitting. In response, providers discussed strategies for quitting or provided smoking cessation resources in 25/47 (53%) of these visits. In the remaining 22/47 (47%), the provider only made a supportive statement but did not provide any advice or assistance. When advice was given, the most common (83%) was use of nicotine patches or gum. Tips, such as removing ashtrays from the home or chewing gum after a meal, and using the Pennsylvania Quit Line were the next most frequent suggestions, occurring in 10/47 (21%) and 7/47 (18%) of visits, respectively.

Conclusion: Only slightly more than half of the obstetric providers offered smoking cessation assistance when patients indicated a desire to quit. Efforts are needed to improve obstetric providers’ counseling responses to women’s smoking cessation desires.

Evaluation of a Curriculum in Motivational Interviewing: The Positive Effects on Patient Outcomes in Tobacco Cessation

Authors: David Richard, Penn State College of Medicine Peter Lewis, Penn State College of Medicine Samuel Faber, Penn State College of Medicine Alan Adelman, Penn State College of Medicine

Teaching
Introduction with institutional context and educational objectives: We have developed a four year longitudinal curriculum to teach medical students patient-centered communication techniques, including Motivational Interviewing (MI), as one way to help patients become engaged regarding behavior change. Behavior change counseling is an essential component of patient care to be practiced by future physicians.

Instructional and/or assessment methods: Medical students are taught the fundamental skills of open-ended questions, affirmations, reflective listening, and summarization (OARS), patient agenda setting techniques, asking permission and the ask/inform/listen paradigm as tools to use in patient-centered communication. Part of our curriculum utilizes a four hour smoking cessation workshop combining didactics, video-taped examples, and standardized patient exercises to practice these techniques. The students must then identify and partner with a patient who smokes tobacco during a clinical rotation and apply these techniques. Both student and patient evaluation of this smoking cessation curriculum and intervention will be presented.

Program evaluation results: Our data have shown that students consider it important to discuss tobacco cessation with their patients who smoke (9.32/10 Likert scale, n=554), that they are comfortable using MI techniques immediately (p<.001, n=143), and four months after the workshop (p=.007, n=143), MI is poorly modeled by faculty (4.34/10, n=554) and that they are quite successful in getting patients to quit (eight year data - 64% of patients quit, 82% found students helpful and 41% would not have quit without student involvement, 8 months post-intervention, n=233).

Discussion/implications: Medical student training in a single four hour workshop in MI resulted in improved student confidence in performing MI and in patients being able to quit their tobacco habit. With behavioral determinants of health resulting in increased medical utilization, teaching such techniques will be of fundamental importance in medical education. Improving faculty utilization of MI to enhance modeling remains an obstacle and opportunity.

Training Members of Veterans Affairs Medical Home Healthcare Teams to Use Motivational Interviewing for Tobacco Cessation

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Introduction/Objectives: Tobacco cessation counseling using motivational interviewing (MI) is promoted for use by various health care professionals as members of patient-centered medical home (PCMH) teams. However, skills and confidence with MI varies. This study assessed the effect of a high-intensity versus moderate-intensity MI training program on MI and tobacco cessation counseling skills, confidence and knowledge among PCMH teams.

Methods: Members of PCMH teams at two Veterans Health Administration facilities were randomized to moderate- or high-intensity MI training (n=32). Both training models included: 1) MI clinical champions and a facility-based MI expert consultant who were trained at a three-day intensive MI workshop, 2) Half day on-site training workshops for PCMH members, and 3) Self-study materials. The high-intensity model added six booster sessions coached by the trained MI champions. Three of these booster sessions used telephone interactions with simulated patients and occurred at four, eight, and 12 weeks after the initial training. The other three booster sessions (at two, six and 10 weeks) used small group coaching facilitated by the champions and focused on specific MI skills.

Participants completed surveys measuring MI knowledge and confidence and tobacco cessation counseling skills and confidence before, and 12 weeks after, on-site training.

Results: Thirty-five PCMH members were enrolled. Thirty-two completed pre- and post-survey. Compared to the moderate intensity group, the high-intensity group scored significantly higher for three...
Discussion/Implications: We believe our approach shows promise for promoting behavior change during clinical interactions. In this pilot study we enhanced both MI and tobacco cessation counseling skills among PCMH members using a training model that went beyond a single didactic session and included several booster meetings, telephone interactions with simulated patients, and mentoring from colleagues trained to be MI champions.

Table. Changes in Self-Reported Knowledge, Counseling Skills, and Confidence (n=12)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Training Group</th>
<th>Pre-Treatment Survey Scores (SD)</th>
<th>3 Months Follow-Up Survey Scores (SD)</th>
<th>Model Estimated Change (SE)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI Knowledge</td>
<td>High Intensity</td>
<td>6 (2.0)</td>
<td>9 (1.7)</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate Intensity</td>
<td>6 (1.0)</td>
<td>9 (1.6)</td>
<td>0.1</td>
<td>0.0402</td>
</tr>
<tr>
<td></td>
<td>Difference</td>
<td>1 (0.2)</td>
<td>3 (0.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI Counseling Confidence</td>
<td>High Intensity</td>
<td>2.8 (0.5)</td>
<td>3.5 (0.4)</td>
<td>0.06 (0.14)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate Intensity</td>
<td>2.9 (0.7)</td>
<td>3.2 (0.4)</td>
<td>0.29 (0.15)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difference</td>
<td>1 (0.2)</td>
<td>0.7 (0.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Cessation Counseling Skills</td>
<td>High Intensity</td>
<td>2.8 (0.7)</td>
<td>3.5 (0.5)</td>
<td>0.06 (0.14)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate Intensity</td>
<td>2.8 (0.5)</td>
<td>3.3 (0.4)</td>
<td>0.21 (0.15)</td>
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<tr>
<td></td>
<td>Difference</td>
<td>1 (0.2)</td>
<td>0.7 (0.2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Minority Health and Racial Disparities

The impact of physician race, gender and communication style on analogue patient receptivity to depression care

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Introduction/Objectives: Contraceptive counseling is central to gynecologists’ provision of well-woman care. Research in this area has focused on the topics covered by Ob/Gyns during contraceptive visits [1]. Little is known about the stylistic mechanics of contraceptive counseling: the “how” of contraception recommendations as opposed to the “what”. Previous studies have indicated that patient-centeredness and shared decisionmaking are particularly important in contraceptive care [2,3], but that specific communicative strategies are poorly understood [4]. Two studies suggest that “impersonal” and/or “coercive” communication may be associated with non-white patients [5,6]. The current study investigates the linguistic structure of contraceptive recommendations and their perceived forcefulness in relation to patient/physician characteristics, hypothesizing an association between strong (i.e., forceful) recommendations, directive semantic/syntactic features, and non-white patients.

Methods: This study utilizes the US-wide Verilogue database [7] of recorded/transcribed physician-patient interactions. 234 Ob/Gyn-submitted conversations were screened for contraceptive recommendations, yielding 102 transcripts (representing 29 physicians) and 192 contraceptive recommendations. Each recommendation was categorized using a 4-point strength scale and independently coded for structural/referential features. Primary analyses utilized Chi-squared tests to assess differences in the distribution of strength and linguistic form across white and non-white patients. A secondary multiple logistic regression analysis included Ob/Gyn years-in-practice, patient age, and contraception type as other potential predictors of recommendation strength.

Results: Significant main effects for doctor style were evident on all ratings in every model; high patient-centered doctors were more favorably rated than low-patient centered doctors for all outcomes regardless of doctor race and gender. There were no significant main effects for doctor gender and race or interaction effects for subject and video doctor race and gender on subject ratings.

Implications: Race and gender concordance is associated with positive patient ratings of care and patient-centered communication in observational studies. These attributes are often confounding making it difficult to disentangle causal pathways. The current study suggests that it is a clinician’s style, rather than sociodemographic characteristics, that drive patient evaluations of depression care.

Patches, pills, and pronouns: Exploring an association between linguistic style and patient race in contraceptive recommendations

Authors: Jonathan Hesson, Michigan State University
Ashley Hesson, Michigan State University

Introduction/Objectives: Contraceptive counseling is central to gynecologists’ provision of well-woman care. Research in this area has focused on the topics covered by Ob/Gyns during contraceptive visits [1]. Little is known about the stylistic mechanics of contraceptive counseling: the “how” of contraception recommendations as opposed to the “what”. Previous studies have indicated that patient-centeredness and shared decisionmaking are particularly important in contraceptive care [2,3], but that specific communicative strategies are poorly understood [4]. Two studies suggest that “impersonal” and/or “coercive” communication may be associated with non-white patients [5,6]. The current study investigates the linguistic structure of contraceptive recommendations and their perceived forcefulness in relation to patient/physician characteristics, hypothesizing an association between strong (i.e., forceful) recommendations, directive semantic/syntactic features, and non-white patients.

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Results: The Chi-squared analyses showed no significant differences in the strength or structure of recommendations given to white (N=100) and non-white (N=92) patients. The multiple regression analysis indicated that directive syntax and increasing Ob/Gyn years-in-practice were the best predictors of strong recommendations.

Conclusions/implications: These findings do not support a relationship between patient race and recommendation strength/structure. They do, however, point to an association between linguistic form and recommendation strength. They also indicate that as Ob/Gyns gain experience, their contraceptive recommendations become more forceful/directive. Future work should explore linguistically informed shared decisionmaking interventions focused on experienced practitioners.

References:

Call2Health: Harnessing the Positive Power of African-American Social Support in Diabetes Self-Care

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Introduction: The Call2Health study helps African-American women improve their diabetes self-care and glycemic control. Patients were randomized into one of two study arms: daily text message only or daily text message + group sessions. The group sessions were designed to create a positive, supportive space for women to explore personal strengths that could be leveraged to improve their diabetes care. Sessions began with “appreciative check ins” to identify and celebrate successes, followed by a guest presenter, interactive discussion, and healthy refreshments. Topics included diabetes self-management information as well as mindfulness-based stress reduction, laughter yoga, Nia movement, grocery shopping on a budget, and fitness without a gym. We are comparing the effectiveness of text messages alone to group sessions plus text messages in improving glycemic control.

Methods: Both groups underwent the six- to nine-month intervention. Our primary outcome is hemoglobin A1C levels; secondary outcomes include changes in daily self-care activities, locus of control, social support, diabetes distress, quality of life, well being, and diabetes knowledge. For group session participants, we also recorded attendance, weekly pedometer totals, and conducted periodic “check ins” to ensure the program was meeting patient needs.

Results: We recruited 47 women into the study; half were assigned to the group visit arm. Not all women attended the sessions due to travel distance, jobs, or health issues. Those who did attend, attended regularly. Our most frequent members attended 6 - 16 times each. We are now analyzing primary and secondary outcome data, but exit interviews indicate that the sessions were well received. Members enjoyed the sessions, learned helpful information, and appreciated the social support. Self report indicates that some are successfully controlling their blood sugar and losing weight.

Discussion: Strengths-based sessions designed to build social support and positive emotions show promise for assisting underserved, African-American women control their diabetes.

Feasibility and Acceptability of a Question Prompt List to Improve Communication and Reduce Racial Disparities in Cancer Treatment

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Introduction: Disparities in cancer treatment are well documented. A potential contributor is that patient and physician negative racial attitudes (e.g., bias, trust) lead to poor quality patient-physician communication, which, in turn, leads patients and/or oncologists to make inappropriate treatment decisions. We assessed the feasibility and acceptability of a communication intervention designed to overcome negative attitudes and improve patient/oncologist treatment decisions in two urban cancer centers.

Methods: The intervention is a Question Prompt List (QPL), designed specifically for this medically underserved setting. Oncologists were recruited from two hospitals in Detroit, Michigan. African American patients were recruited before visiting their oncologists to discuss
A Web-Based Intervention to Improve Primary Care Providers’ Communication Skills and Reduce Racial Disparities in Blood pressure Control among Patients with Hypertension

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Introduction/objectives: Racial disparities in patient-provider communication have been documented among patients with hypertension. African Americans also report lower levels of adherence to BP medications. Few provider communication interventions have been tested to address disparities in hypertension control. As part of a pragmatic trial to improve BP control and reduce racial disparities in care of hypertension, we developed an educational intervention to increase primary care provider (PCP) awareness of disparities in BP control and improve their communication skills related to medication adherence.

Methods: The intervention design was informed by feedback from 45 PCPs at 6 study clinics. Feedback was elicited in focus groups exploring provider opinions about barriers to BP control and reactions to the proposed intervention, which included: 1) a provider level dashboard reporting BP control rates in the patient panel stratified by race; and 2) a web-based communication skills training program. The effectiveness of the communication skills training program is being evaluated by measuring changes in PCP self-reports of using specific communication skills from baseline to 6 months post training and changes in patient ratings of interpersonal care from PCPs pre and post intervention. PCP satisfaction with the program will also be measured.

Results/Discussion/Implications: The dashboard metric is the percentage of patients within each PCP’s panel who have reached BP control within that quarter, stratified by patient race and updated on quarterly basis. The communication skills training consists of brief video-clips from three unique patient encounters and demonstrates communication skills related to assessment of medication adherence issues and partnership strategies to overcome them. Before implementation at 2 clinics, approximately 70% of PCPs report using assessment behaviors most of the time; however, only 29% report brainstorming and problem-solving with patients, and 21% report using “teach back” most of the time. We will report early findings from 4 clinics.

Teaching-Evaluation

Faculty Development Simulation-based Workshop: Effective Communication with Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Patients

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Joseph Gallego, Mayo Clinic Rochester
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Introduction: Population-specific care programs have gained prominence for their effectiveness at providing services that meet unique gender and social needs. The Program in Professionalism and Ethics (PPE) at Mayo Clinic Rochester (MCR) conducts communication workshops. As part of an ongoing faculty development program, a novel simulation-based workshop on effective communication with Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) patients was created. The learning objectives included knowledge, skills and attitudes relative to appropriate and effective communication with LGBTI patient as well as demonstration of communication skills using patient actors.

Instructional and assessment measures: The 4 hour workshop was developed by a PPE curriculum group, and involved bench marking with existing external curriculum, literature searches, institutional resources and consultation with content experts. Instructional methods include mini-didactics, facilitated large group discussion, video vignettes with reflection/discussion, spectrum charting activity, skills practice with patient actors, simulation debrief, actor feedback. Assessment measures include an immediate post workshop evaluation.

Program evaluation results: Nine faculty attended the workshop. Overall rating and degree to which the learning objectives were met was considered “excellent” on a five-point scale by all respon-
The reliability of a modified Kalamazoo Consensus Checklist for assessing the communication skills of clinicians in the simulated environment

Authors:
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Elizabeth Rider, Harvard Medical School/Boston Children’s Hospital
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Introduction: The Kalamazoo Essential Elements Communication Checklist was developed and adapted as an assessment tool for teaching and learning communication skills. Two published psychometric studies of a modified checklist have demonstrated good internal consistency. However, neither evaluated inter-rater reliability or included multidisciplinary learners. Our goal was to demonstrate the internal consistency and inter-rater reliability of the modified checklist used to assess multidisciplinary clinicians.

Methods: PACE (Program for the Approach to Complex Encounters) is a curriculum in which multidisciplinary clinicians simulate challenging conversations with a patient family. For assessment, a modified Kalamazoo Essential Elements Checklist of 9 communication elements was used, with learners, faculty, and standardized patients rating each element on a 5-point Likert scale (1=Poor, 5=Excellent). For testing validation, faculty ratings were used. Cronbach’s alpha was calculated (both for the entire dataset and rater-specific values) to assess internal consistency and Intra-class Correlation (ICC) was used to assess inter-rater reliability.

Results: 118 cases were used to calculate Cronbach’s Alpha. Sessions with 3 faculty raters (N=44) were used to calculate ICC. The tool demonstrated good internal consistency (Alpha score 0.844; rater average 0.852). Element-specific ICC scores ranged from 0.527-0.800 with the lowest ICC’s noted for the elements of Communicates accurate information and Shares accurate information (0.527 and 0.563, respectively). The overall ICC was 0.830.

Discussion: This is the first study examining inter-rater reliability of faculty raters for a modified Kalamazoo Checklist used for multidisciplinary clinicians. Two elements showed poor inter-rater reliability, perhaps indicating a wider variance in the perceived meaning of these elements. Communicates accurate information was not original to the 1999 Essential Elements Checklist, and its low ICC calls into question its usefulness as an additional element. Overall, the modified Kalamazoo remains a useful tool for assessing communication skills of multidisciplinary clinicians as demonstrated by high internal consistency and inter-rater reliability.


Videotaped Interactions: An Effective Communication Skills Training Tool

Authors:
Caroline Porr, Memorial University of Newfoundland

Videotaping simulated nurse-patient interactions is widely recognized as an effective communications skills training strategy. Nurse educators employ videotaped interaction assignments in courses designed to teach nursing students how to establish therapeutic relationships with their patients. Observation, self-awareness, and analysis of verbal and nonverbal communicative behaviours assist the nursing student to identify specific behaviours that may promote or hinder development of a therapeutic relationship. Nursing students work in pairs to role-play nurse-patient interactions which are videotaped and subsequently evaluated for proxemics, kinesics, facial expression, voice-related behaviors, effective use of questioning and therapeutic listening responses. During this presentation the audience will be provided student appraisals of the videotaped interaction assignments and real-life examples of how students have learned nonverbal attending behaviors and facilitative verbal communication techniques including open-ended questions, paraphrasing, reflecting skills and seeking clarification. In addition the audience will be offered hands-on opportunities and assessment tools to promote and critique interpersonal approaches and techniques.
Assessing third-year medical students’ ability to address a patient’s spiritual distress using an OSCE case

Authors: Felise Milan, Albert Einstein College of Medicine
Mimi McEvoy, Albert Einstein College of Medicine
Sheira Schlair, Montefiore Medical Center
Zsuzsanna Sidlo, Albert Einstein College of Medicine
William Burton, Albert Einstein College of Medicine

Purpose: Inform curricular development by assessing the ability of third-year medical students (MS-3s) to address a patient’s spiritual distress during an acute medical crisis in the context of an observed standardized clinical examination (OSCE) case.

Methods: Between March - April 2010, 170 MS-3s completed an eight-station videotaped OSCE at Albert Einstein College of Medicine, Bronx, NY. One of the standardized patients (SP) is a 65 year-old man with acute chest pain who mentions his religious affiliation and fear of dying. If prompted, he reveals his desire to speak with a chaplain. In a written exercise after the encounter, students reported the nature of the patient’s distress and their response to it via four open-ended questions. The SP assessed students' history taking, physical examination and communication skills. Mixed methods analysis of the post-encounter notes was conducted by three independent coders using NVivo 8 for emergent themes. Clinical skills performance was compared between students who reported making chaplain referral and those who did not.

Results: 64% of students reported making a chaplain referral; 2% directly addressed the patient’s religious/spiritual beliefs. Students’ clinical performance scores (history taking, physical examination and communication skills) did not differ significantly by report of chaplain referral.

Conclusions: Many students reported making a chaplain referral in response to a patient in spiritual distress; few explicitly discussed the patient’s beliefs. Clinical skills performance was not associated with report of chaplain referral. Future studies are needed to develop more precise assessment measures that can inform curricular development in spirituality and medicine.

Health Literacy

A Randomized Trial Testing Enhanced Labeling to Increase Awareness of Concomitant Use of Acetaminophen

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Kara Jacobson
Marina Serper
Stacy Bailey
Ruth Parker

Objective: We sought to evaluate two viable labeling and counseling strategies to communicate risk of concomitant use of acetaminophen-containing products.

Methods: We conducted a three-arm, randomized controlled trial that used structured, in-person cognitive interviews among 662 adult patients receiving care at outpatient general medicine clinics in Atlanta and Chicago. Patients were assigned one of the three arms (Usual Care, Written, Written + Verbal) and asked to engage in two primary tasks. The Usual Care arm participants were shown only ‘standard’, currently available OTC and prescription medicine bottles. Subjects in the Written Orientation arm were exposed to bottles ‘enhanced’ with an acetaminophen icon (‘Ac’), while also being exposed to a flier describing the safe usage of acetaminophen. Participants in the Written + Verbal Orientation arm also received standardized verbal counseling. The effectiveness of either intervention compared to usual care was determined via 1) risk of concomitant use, or the perceived safety of simultaneously taking two acetaminophen-containing products and 2) accurate identification of acetaminophen-containing products.

Results: Participants were younger to middle-aged, two-thirds were female, and there was considerable diversity within the sample by race/ethnicity and socioeconomic status. There were no statistically significant differences in participant characteristics across study arms. After controlling for individual risk factors (age, literacy level, recent OTC pain experience), those receiving the written+verbal instructions demonstrated the greatest knowledge and/or ability to correctly identify concomitant use warnings, while both written and written+verbal subjects were both better able to identify active ingredient compared to usual care. Lower literacy skills was consistently found to be a significant risk factor to poorer understanding of active ingredient and concomitant use.

Discussion: Compared to current labeling practices, participants demonstrated improved ability to identify active ingredients in OTC and prescription products only when provided with an icon and enhanced messaging along with a written flyer and verbal communication. Enhanced labeling alone was insufficient to increase awareness.
Advancing Patient-Centered Drug Labeling: A Focus on Challenging Medication Instructions

Authors: Stacy Bailey, University of North Carolina at Chapel Hill
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Introduction: Current initiatives to improve prescription medication labeling have focused on chronic, pill-form medications. To expand upon these efforts, our study sought to incorporate health literacy ‘best practices’ and a patient perspective into the re-design of instructions for: 1) non-pill form, 2) acute, 3) ‘as needed’ and 4) tapered and escalating dose medications.

Methods: We conducted three iterative waves of individual interviews and discussion groups from December 2012 - March 2013 in Chicago and San Francisco. Adult, English-speaking patients were recruited via convenience sampling. Literacy was assessed via the Rapid Estimate of Adult Literacy in Medicine; patient socio-demographic and health characteristics were also collected. During the discussion groups, participants were shown a series of standard and enhanced instructions to prompt dialogue and generate ideas for improvement.

Results: To date, 31 patients have participated in the study (n=20 in San Francisco, n=11 in Chicago). Participant ages ranged from 21 to 67 (mean = 44), 32% were male. On average, participants took 3.6 medications and had 2 chronic conditions. Patients varied sociodemographically; 29% had limited literacy skills. Common themes from discussion groups included: the need for simpler terminology and specificity, tying medication use to explicit times of day, and the need for external aids and counseling to support tapered dosing. Consensus was reached on how to rephrase instructions for inhalers, injections, and as-needed medications. Greater disagreement was expressed over: 1) measurement terminology for liquid drugs and 2) the location of ‘duration of use’ information for acute medications.

Discussion: Through this process, we have developed a set of patient-centered, health literacy-informed instructions for some of the most challenging medications. Additional focus groups are planned for further refinement; an evaluation among 250 patients will be conducted in 2013. Resulting instructions can support current and future initiatives to promote comprehensive, patient-centered drug labeling.

Development of the Dutch/Turkish Talking Touch Screen Questionnaire

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Introduction/context: In the Netherlands there is a strong call for transparency in health care. Therefore physical therapists are encouraged to monitor their care processes by asking their clients to fill out health related questionnaires before and after treatment. A considerable group of clients are unable to fill out such a questionnaire independently. The main underlying problem of Dutch native as well as immigrant clients seems to be their level of (health) literacy. American and Chinese research shows that the use of a Talking Touch Screen (TTS) increases the ability of low (health) literate clients to fill out questionnaires, even if they have limited or no computer skills. For this reason a Dutch/Turkish TTS Questionnaire (DTTSQ) was developed.

Description of policy or practice innovation: Different from the development process of the American and Chinese TTS, a User Centred Design method was used. This involved an iterative development process in which (future) users and researchers collaborated as equals. Tools and techniques for co-creation/co-design have enabled users to take on the role of ‘expert of their experiences’ and become part of the design team. In co-designing, the researchers took on the role of facilitators. User needs were discovered through focus groups. A prototype was developed through generative prototyping and scenario building.

Evaluation/impact: Usability of the DTTSQ (n=102) was compared to the usability of a questionnaire on paper with similar content (n=121). Throughout all literacy levels clients were significantly better able to independently fill out the DTTSQ. Additional qualitative research shows that clients are satisfied with the usability of the DTTSQ and physical therapists are inclined to incorporate this innovation into their daily practice.

Discussion/implications: The prototype of the DTTSQ enhances the ability of Dutch and Turkish physical therapy clients across all (health) literacy levels to independently fill out a health related questionnaire.

Patient and regimen characteristics predict medication errors after hospital discharge

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Introduction/Objectives: After hospital discharge, differences may exist between what medications patients think they should be taking and what is ordered. We examined the association of health literacy, numeracy, and other factors with such medication errors.

Methods: As part of a prospective cohort study of hospitalized cardiac patients, medication errors were determined by comparing discharge medication lists to what patients reported taking during a phone interview in the week following discharge. We used logistic regression to examine predictors of different types of medication errors - discordance between the presence of a medication on the discharge list and the patient-reported list; errors of omission and commission; and for cardiac medications, discrepancies in indication, dose, and frequency.
Results: Among 473 patients, 51% had at least one discordant medication (i.e., it did not appear on both the discharge list and the patient-reported list). Over one-quarter (27%) of patients were not taking a medication that they were supposed to be taking per the discharge list (an omission), while over one-third (36%) were taking a medication not listed on the discharge list (error of commission). Nearly 60% of patients reported a discrepancy in indication, dose, or frequency for at least one cardiac medication on the discharge list. In adjusted analyses, higher subjective numeracy was associated with lower odds of having discordant medications (OR=0.90, 95% CI 0.82-0.99). For cardiac medications, higher health literacy (OR=0.96, 95% CI 0.94-0.98) and higher subjective numeracy (OR=0.82, 95% CI 0.72-0.94) were associated with lower odds of having discrepancies in indication, dose, or frequency. A greater number of medications, older age, more medication changes during hospitalization, worse cognitive function, and male gender were also associated with medication errors.

Discussion/Implications: Medication errors were identified frequently in patients recently discharged. Lower health literacy and numeracy, among other factors, are associated with more medication errors.

Social Issues

Project IMPACT: A Network Perspective on Community Leadership, Health Disparities and Public Opinion Change

Authors:
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Introduction & Objective: Our study examines the role of community leadership in changing the public agenda about health disparities. Community-wide mobilization to eliminate disparities demands a closer understanding of the perceptions of community leaders from different sectors, including the dynamics of their relationships. Accordingly, we describe an approach for mapping the social and communicative dynamics of leaders, with an eye toward leveraging these dynamics to ease health disparities.

Methods: Data come from 33 interviews with community leaders in Lawrence, MA. We used NVivo [1] to uncover themes regarding leaders’ views on public health, health disparities and communication inequalities - differences among social groups in the generation, manipulation, and distribution of information at the group level, and differences in access to and ability to take advantage of information at the individual level [2]. Next, we combined the output from NVivo with sociodemographic data to create and analyze network diagrams with UCINET [3]. By “toggling” between network diagrams and interview data, we were better able to analyze the rich themes contained in the transcripts.

Results: Community leaders in Lawrence do perceive the existence of health disparities and communication inequalities, including the lack of culturally-sensitive information for Latinos and poor media coverage of health topics. But some perceive differences at the individual level only - suggesting difficulty in understanding the structural roots of health disparities. Further analysis of ego-centric leadership networks suggests intersectoral partnerships that could help to spread information about structural level inequalities and facilitate public opinion change over time.

Discussion/Implications: By offering a means to assess communicative dynamics among leaders, and how these dynamics may influence actions to address health disparities, our research suggests a pathway for developing interventions to address a variety of disparities in communities around the nation and world.

References:

Physicians’ and patients’ perceptions concerning socially responsive healthcare communication in a context of poverty

Authors:
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Duncan Sanderson

Introduction: Patients living in poverty report negative healthcare experiences, unmet needs, and sometimes feel stigmatized by healthcare professionals. Physicians face considerable challenges in delivering care to people living in poverty. Patients’ capabilities and living conditions need to be better addressed in the care relationship. We lack knowledge in relation to the communication skills and useful strategies of care developed by physicians who work in deprived areas with high levels of poverty.

Objective: To identify and discuss factors which enhance the quality of communication between family physicians and patients living in poverty.

Methods: Our study employed a qualitative ethnographic approach in five primary care practices in disadvantaged neighborhoods in Montreal (Quebec, Canada), including observations and interviews. We observed the functioning of the primary care practices, physician-patient encounters, and staff meetings. We used a dyadic data collection approach by conducting paired semi-structured interviews with physicians and some of their patients who live in poverty. Data analysis consisted of debriefing sessions, coding of transcriptions with data analysis software and interpretative analysis.
Results: Our results highlight the considerable agreement, between physicians and their patients, concerning the aspects of communication that they perceive as socially responsive. Both physicians and their patients agreed that humanistic attitudes and reciprocal engagement are fundamental elements of effective communication. In addition, patients emphasized that a warm welcome and flexible access to the physician had a positive impact on their communication with the physician. Physicians recognized that specific strategies of patient-centered care are needed with persons living in poverty. The spatial characteristics of the clinic environment that sustain opportunities to engage in informal conversations with different professionals or with patients were also important factors.

Discussion: This study provides original data that can be used to develop new patient-centered chronic care interventions to better address the living conditions and expectations of people living in poverty.

What effect does policy implementation have on practitioner-client engagement? A qualitative exploration into homelessness

Authors: Ruth Freeman, University of Dundee, Emma Coles, University of Dundee

Background: Homelessness policy in Scotland has required NHS Boards to implement the Health and Homelessness Standards to ensure that mainstream health services are readily accessible to those experiencing homelessness. The degree to which the ‘Standards’ have been incorporated into Board policy has remained piecemeal, however, the effect that this has on practitioner-client engagement remains unknown.

Aim: To explore the effect of homelessness policy implementation at NHS Board level on practitioner engagement behaviours with clients at the community level.

Method: An ethnographic approach included unstructured interviews with 18 practitioners and participative observation of the workings of 7 NHS Boards in implementing the Standards. The data was analysed using framework analysis.

Results: Observations of participants’ behaviours at NHS Board meetings of health and homelessness service groups permitted the degree of practitioner commitment to their homeless clients to reflect the Board’s degree of policy implementation. NHS Boards with complete implementation had strong leadership, partnership working and practitioners with high morale; NHS Boards with poor implementation lacked leadership, resulting in fragmented services and low practitioner morale. Practitioners’ engagement behaviours, in Boards with poor implementation, emerged as ‘mediating tactics’ to counter the effect of poor policy implementation while creating an opportunity for client communication to enable client access to mainstream services. The mediation tactics were conceptualised as a 3-stage process to uphold the Standards and to ensure clients accessed mainstream services. This 3-stage mediating process emerged as (1) identifying suitable (easy) clients; (2) engaging and communicating; (3) enabling clients to move-on and access mainstream services.

Conclusions: Practitioners working in NHS Boards with poor implementation of the ‘Standards’ experienced a work environment characterised by lack of leadership, fragmented services and poor morale. To counteract the effects of poor policy implementation, practitioners’ engagement behaviours emerged as a series of tactics to enable client to access mainstream services.

Improving the primary care experience of people living in poverty and suffering from multimorbidity: The role of socioaffective communication

Authors: Cristina Grabovski, University of Sherbrooke, Christine Loignon, University of Sherbrooke, Martin Fortin, University of Sherbrooke

Introduction/objectives: Numerous studies have shown that effective communication enables health professionals to better care for their patients and plays a fundamental role in the adherence and treatment response. However, a growing body of research is highlighting the presence of serious barriers to communication when it comes to patients living in poverty. In cases where these socioeconomically disadvantaged individuals also suffer from two or more chronic diseases, their vulnerability increases and the communication context of the “physician-patient” dyad becomes ever more complex. This exploratory qualitative research aims to identify the socioaffective factors that could improve the communication between physicians and vulnerable patients.

Methods: We performed a secondary analysis of data from a study adopting an ethnographic approach in primary care. Transcripts of the semi-structured interviews on the primary care experience of multimorbid patients living in poverty have been analysed using thematic content analysis and interpreted with regards to the conceptual framework of the immediacy theory (Mehrabian, 1971; Andersen, 1979).

Results: In total, twenty-two patients participated in our study. The results suggest that the instrumental (or results-oriented) communication between patient and physician is enhanced by an effective socioaffective communication. The most important aspects of physician’s socioaffective communication valued by patients were linked to: (1) the communication of affection through nonverbal emotional cues: the importance of welcoming, listening and spending time; (2) the communication of affection through verbal emotional cues: the patient viewed as human being by the physician; (3) the communication of affection through verbal emotional cues: the physician viewed as human being by the patient; and (4) the communication of cohesion and interactivity: the patient and his physician as (friendly) team.

Discussion/implications: We propose the term “physician immediacy” as a component of the social competence model in primary care (Loignon et al., 2010). The concept of immediacy is used to describe the socioaffective communicational behaviors that reduce the perceived distance between physicians and their economically disadvantaged patients suffering from multimorbidity. Results could be used to improve medical education by better preparing medical students for communicating with vulnerable patients.
Patient Preferences

Exploration of Patient Preference Statements

Authors:

Maria Venetis, Purdue University
Jeffrey Robinson, Portland State University

Research suggests that patient-centered care (PCC) contributes to improved patient outcomes such as reduced anxiety and improved quality of life (e.g., Stewart et al., 2000; Venetis, et al., 2009). PCC is multi-faceted and includes understanding patients' needs and perspectives, honoring patients' values, and encouraging patients to participate in the medical interaction and decision making as desired by the patient (Epstein et al, 2005). One particular behavior that embodies PCC is patient assertive responses of stating preferences (Street & Millay, 2001). Within the breast cancer-communication context, patient preference statements are associated with meaningful immediate patient psychosocial outcomes such as increased satisfaction and improved coping (Robinson et al., 2012). However, recognizing that communication is interactive, providers’ responses to patient preference statements, and not necessarily patients’ preference statements themselves, may contribute to improved patient outcomes. Self Determination Theory (Ryan & Deci, 2000) argues that autonomous behavior (e.g., patient preference statements) and autonomy-supportive behaviors (e.g., provider encouragement of patient choices) promote better individual well-being. In order to better understand preference statements, this exploratory study examines a corpus of 86 video-recorded, surgical-treatment discussion making conversations between surgeons, patients, and companions. Coders identified and coded all preference statements and surgeon responses. Among the 86 cases, preference statements were present in approximately 50 cases. Content analysis of preference statements revealed that patients and companions most frequently stated preferences concerning reconstructive options and surgical logistics such as day of the week or hospital location. Quite infrequently patients state which surgical treatment is preferred (e.g., lumpectomy vs. mastectomy). Provider responses range from minimally supportive, supportive, and autonomy-controlling. The manuscript describes patterns of patient and companion preference statements in the breast cancer treatment decision-making conversation, including lack of preference statements, as well as patterns of provider response. Study and theoretical implications are also discussed.

Identifying Values, Needs, and Preferences for Cognitive Rehabilitation in Patients with Multiple Sclerosis

Authors:

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Introduction / objective: The main goal of this study was to identify values, needs, and preferences for cognitive rehabilitation in patients with multiple sclerosis (MS).

Methods: Twenty consecutive patients with MS were recruited from University of Maryland Center for Multiple Sclerosis. The participants were consented at the MS clinic, completed a set of questionnaires, and were asked to use gaming software ‘Brain Spa’ developed to evaluate cognitive level and to provide cognitive exercises. Attitudinal surveys and semi-structured qualitative interviews were administered after patients were exposed to the gaming software. A linear regression model was used to identify predictors of acceptance of cognitive exercises. The model included age, race, education, Kurtzke Expanded Disability Scale Scores (EDSS) and frequency of computer use at home.

Results: The mean age was 41 years old and 90% were women. On average, patients spent 2.8, 2.9, 3.5, and 1.6 minutes to complete language, logic, memory and perception sections; 70% reported that the rules of the games were not complicated at all; 100% responded that playing games may have a significant effect on their brain power. The qualitative interviews demonstrated high level of acceptance of using gaming software for cognitive rehabilitation. The patients mentioned that “The games make me think,” and “I am not as sharp as I used to be and these games could help me improve my memory with repeated use.” From the linear regression model, less education, computer use at home once a week or less, and being an African American were significant factors predicting gaming acceptance.

Discussion/implications: The MS patients expressed their eagerness to utilize gaming software to maintain their cognitive function. Years of education, computer use at home, and race predicted the acceptance of gaming as a means for cognitive rehabilitation in MS patients.

At Ease and Dis-ease: Patient Requests for Reassurance

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Richard Moore, Johns Hopkins University

Background: Reassurance is an important aspect of patient-physician interactions, but little is known about the circumstances under which patients explicitly request it. Our study examined how and when patients make requests for reassurance from their physicians in routine outpatient encounters.

Methods: We analyzed encounters between 45 providers and 418 HIV-infected patients. We used the Roter Interaction Analysis System (RIAS) to identify all explicit patient requests for reassurance. We qualitatively analyzed these requests, and used logistic regression with generalized estimating equations to compare characteristics of patients who made vs. did not make a request for reassurance.

Results: In 418 encounters, there were 53 encounters with at least one request and 72 total requests for reassurance. There were no differences in age, gender, race/ethnicity, education, health literacy or social support between those who did vs. did not request reassurance; however those requesting reassurance reported more depressive symptoms. Qualitative analysis generated eight categories describing...
the topic of patient requests: overall health, symptom/illness, physical exam, therapy, testing logistics, interpreting personal data, general information, and administrative. The most common category was interpreting personal data such as vital signs and test results (e.g. “So is that good or bad?”), followed by requests regarding therapy (“If I’m taking the Fuzeon, is it gonna be forever?”) and symptom/illness (“Do you all think I might have cancer of my stomach?”). While there were only four requests regarding overall health, these carried a great deal of emotional weight (“Am I gonna have the days again where I just feel good?” and “I just want to know when I can… will I be all right?”).

Conclusions: Our study demonstrates that patients do not often request reassurance explicitly. Future studies could examine whether physicians should look for opportunities to offer reassurance even if not requested, particularly among patients with depressive symptoms.

Conversational Elements Impeding Transplant Candidates’ Discussion of Live Donor Kidney Transplantation

Author: Heather Traino, Virginia Commonwealth University

Introduction/Objectives: Live donor kidney transplantation (LDKT) is the preferred treatment option for patients with chronic and end-stage renal disease (ESRD). However, many patients have reported difficulties initiating and managing discussions about LDKT and requesting living donation. Limited communication about LDKT has demonstrable impact on patients’ access to transplantation, the duration of dialysis treatments, and the length of time awaiting a transplantable kidney. This study was conducted to inform the design of an educational program aimed at facilitating patients’ discussions about transplantation, including LDKT. Specifically, the study sought to identify the specific communicative and conversational elements impeding ESRD patients’ discussions about LDKT.

Methods: From March through July 2012, semi-structured telephone interviews (n=63) were conducted with ESRD patients waitlisted for kidney transplantation at one mid-Atlantic transplant center. The interviews assessed patients’ communication confidence (i.e., self-efficacy), transplant knowledge, perceived difficulty managing various aspects of LDKT discussions (i.e., initiating discussion, addressing fears and/or concerns, answering questions), perceived impact of LDKT discussions on relationships with others, and intentions for future conversations.

Results: Although 85.7% (n=54) of patients reported holding discussions about transplantation, qualitative analyses of open-ended responses revealed that the majority (66.7%) had limited or superficial conversations. Only 41.3% had ever requested living donation from another person. Results revealed moderate knowledge of LDKT, with 52.4% correctly answering all knowledge questions; however, patients reported difficulties managing a variety of logistical and content-related aspects of LDKT discussions. Moderate levels of communication self-efficacy were also found (Mean = 19.2 out of 28); self-efficacy was highest among respondents having held discussions and was significantly related to perceived magnitude of difficulty handling conversational aspects.

Discussion/Implications: This study is the first to quantitatively assess ESRD patients’ transplant-related communication self-efficacy. Results support comprehensive communication skills training for ESRD patients awaiting kidney transplantation. Potential topics to be included in such training are discussed.

Communication-Interventions

Preoperative Anxiety - Effectiveness of a nursing educational intervention

Authors: Silvia Goncalves, Faculty of Medicine, University of Porto
Margarida Figueiredo-Braga, Faculty of Medicine, University of Porto

Abstract: A considerable number of patients experience anxiety prior to elective surgery, affecting physical and mental health. Information provision and educational programmes have been confirmed as efficient and adequate approaches to reduce preoperative anxiety.

This study had the main objective of determine the effectiveness of an educational program applied by nursing professionals in the reduction of preoperative anxiety among hospitalized patients awaiting elective surgery.

Following a single blinded, randomised controlled trial design, the study included 100 consecutive patients admitted for elective surgery in a Urology Service. Participants were randomly allocated to an intervention (n=34), and to two controls groups: control group A (n=33) received standard information on surgical procedures, and control group B (n=33) was submitted to routine procedures. The intervention consisted of a brief interview eliciting specific triggering and predisposing factors for preoperative anxiety. Subsequently, personalized and standardised information was provided and emotions response strategies, support strategies and patient resource amplification strategies were implemented. Pre and post intervention anxiety level was assessed using State-Trait Anxiety Inventory (form Y).

At hospital admission, anxiety levels detected were similar in all the groups (49.4 SD10.3). The reassessment after the intervention revealed a statistically significant lower level of anxiety in the experimental group (51.7 compared to 37.8, p <0.05). In control group A, receiving standardized information, anxiety presented similar levels at reassessment. In control group B submitted to routine procedures, a statistically significantly increased level of anxiety was observed in the second evaluation (49.1 compared to 50.7, p <0.005).

Conclusions: Increasing levels of anxiety were observed during hospitalization when routine nursing hospital care was applied. Conversely, the brief educational intervention provided was effective in reducing preoperative anxiety, confirming the efficacy of a patient-centred approach delivering tailored information and emotional support easily applied by nursing professionals.
Interventions to enhance informed consent in healthcare: systematic review

Authors: Adrian Edwards, Cardiff University, Paul Kinnersley, Cardiff University, Katie Phillips, Cardiff University, Katie Savage, Cardiff University, Mark Kelly, Cardiff University, Elinor Farrell, Cardiff University, Robert Whistance, Bristol University

Introduction: Achieving informed consent is a complex process and requires that patients have information they can understand and retain, opportunities to consider their options and can express their opinions. Informed consent is not uniformly achieved.

Objectives: To assess the effects on patients, clinicians and services of interventions to improve patients’ consent for invasive healthcare procedures.

Method: Systematic review; searching CENTRAL, MEDLINE, EMBASE and PsycINFO (no language/date restrictions), reference lists of included articles; dual data extraction; narrative synthesis; meta-analyses.

Results: 65 RCTs included, with 9021 patients, from 12 countries. Interventions used various formats including: written materials; audio-visual; decision aids. Some were delivered before hospital admission while others were delivered on admission.

Only one study measured informed consent as a unified concept. Generally studies measured components of informed consent (e.g. knowledge; anxiety; satisfaction with consent process). Other outcomes were deliberation, decisional conflict, procedure uptake and consultation length.

Meta-analyses showed statistically significant improvements in knowledge immediately after interventions (SMD 0.53 (95% CI 0.37-0.69); from 24 hours to 15 days (SMD 0.68 (95% CI 0.42-0.93) and at >15 days (SMD 0.78 (95% CI 0.50-1.06). Satisfaction with decision making was increased (SMD 2.25 (95% CI 1.36-3.15) and decisional conflict reduced (SMD -1.80 (95% CI -3.46 to -0.14). There were no statistically significant differences for generalized anxiety, anxiety with the consent process and satisfaction with the consent process.

Interventions before hospital admission did not affect patient anxiety about the consent process: SMD -0.12 (95% CI -0.33 to 0.09); interventions at the time of admission increased anxiety SMD 0.41 (95% CI 0.19 to 0.62).

Conclusions: The interventions consistently improved patient knowledge, an important prerequisite for informed consent, and without harmful effects such as anxiety. Wider use of integrated informed consent measures are needed to better understand the effects of informed consent interventions.

Engaging youth through a spoken word type 2 diabetes prevention social marketing campaign

Authors: Elizabeth Rogers, UCSF Primary Care Research Fellow, Sarah Fine, University of California, San Francisco, Margaret Handley, University of California, San Francisco, James Kass, Youth Speaks, Purba Chatterjee, University of California, San Francisco, Dean Schillinger, University of California, San Francisco

Introduction: Type 2 diabetes (DM2) prevalence is rising among minority youth. There is an unmet need to engage youth in addressing the social conditions that create this risk. A youth-targeted social marketing campaign may be one avenue toward engagement.

Aim: To evaluate the effectiveness of “The Bigger Picture,” a youth-generated, youth-targeted social marketing campaign for improving knowledge, attitudes and behaviors about preventing DM2.

Methods: Through a partnership between UCSF Center for Vulnerable Populations and Youth Speaks, a youth arts organization, we used a participatory approach that engaged youth poets to create 12 web-based public service announcements (PSAs) addressing the social and environmental conditions that increase DM2 risk. After two pilots, the campaign is underway, including youth poet-delivered assemblies and writing workshops at 15 high schools in underserved neighborhoods. We are using audience response systems during poet-led high school assemblies and paper pre/post surveys administered at writing workshops to collect data about demographics, knowledge, attitudes, and lessons learned.

Results: We will show 2 representative PSAs from http://youth-speaks.org/thebiggerpicture/. We will report on the evaluation outcomes of “The Bigger Picture” high school presentations and their effect on change in short-term knowledge and attitudes among >2,000 students, and describe the impact of the workshops to engage youth about DM2 prevention.

Discussion/implications: A youth-targeted, youth-generated social marketing campaign may be an effective way to activate diverse, high-risk youth to become agents of change to reverse the social and environmental conditions that increase DM2 risk.

Sustainability of a Pediatric Resident Communication Skills Intervention on Teachback Skills

Authors: Mireille Boutry, Case Western University School of Medicine, Robyn Strosaker, Case Medical Center, Sharon Meropol, Case Western Reserve University School of Medicine

Background: Effective physician-patient communication is a key component in the delivery of safe, high quality health care. Health
literacy awareness and improved communication increase both patient satisfaction and patient outcomes. We evaluated a multi-modal educational intervention to assess and improve patient interaction and communication styles taking into consideration obstacles to care including health literacy, economic situation, home environment, and stress level. Residents received group and individual feedback on communication skills from 2 faculty members and a social worker. Efficacy was demonstrated 4 months post-intervention using video-taped simulated interviews of standardized parents pre- and post-intervention. Post-intervention, resident use of “Teach-back” improved from 3% to 68%. Most of the residents who did not improve on the use of Teach-back had missed at least part of the educational intervention.

Objective: This follow-up study evaluates the sustainability of and obstacles to educational gains 24 months following the intervention.

Design/Methods: Pediatrics and medicine-pediatrics residents (n=29) participating in the original study are surveyed on their “Teach-back” experience in their third year of training.

Results: The follow-up survey to determine sustainability of educational gains and possible obstacles encountered in the performance of this communication technique is in progress.

Conclusions: Demonstrated improvement of communication skills, using “Teach-back” methods in a structured curriculum including videotaped sessions with standardized parents may not be sustained. The sustainability of these educational gains and potential barriers to the implementation of these skills will be demonstrated in our study. Results will be shared and discussed at the time of our presentation.

Impact of an Electronic Health Record on Medical Students’ Behavioral Counseling Skills

Authors: Carol Pfeiffer, UConn School of Medicine, Laurie Carines, University of Connecticut SOM, Rebecca Kosowicz, University of Connecticut SOM

The impact of the Electronic Health Record (EHR) on clinicians’ communication skills has been only partially explored. The purpose of this study is to explore the outcomes of standardized patient (SP) encounters with and without the computer as a source of patient data and patient education.

Methods: First year students at the University of Connecticut SOM learn and practice behavioral counseling skills during the first semester of their Clinical Medicine Course. During class in November, they practiced using a mock EHR as they did exercise counseling with a peer. In December, they had a formative evaluation encounter with two Standardized Patients (SPs). Their tasks were to take a complete history and counsel the patient about either exercise counseling or smoking cessation. Prior to 2012, the students made no use of an EHR in their work with the SP. In 2012, they had patient information about smoking cessation. Prior to 2012, the students made no use of an EHR, but that there is a significant improvement in the counseling performance using the EHR. This is a small piece of evidence that an EHR need not interfere with behavioral counseling and may in fact help the process.

<table>
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<td>85 ± 06</td>
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<td>Counseling</td>
<td>78 ± 10</td>
<td>84 ± 11</td>
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<tr>
<td>MIRS</td>
<td>4.2 ± 3</td>
<td>4.1 ± 3</td>
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<td>MIRS</td>
<td>4.1 ± 3</td>
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Results: Data from the assessments are in Table 1.

Conclusion: The results indicate that students have comparable scores on history and MIRS across the two years for both cases. The data show that there is little change in the counseling performance with no EHR, but that there is a significant improvement in the counseling performance using the EHR. This is a small piece of evidence that an EHR need not interfere with behavioral counseling and may in fact help the process.

Teaching-Evaluation

Teaching End-of-Life Communication

Author: Michael Pagano, Fairfield University

This paper will describe a unique course in teaching pre-health, communication, and nursing students how to communicate with dying patients and their families. The goal of this paper is to discuss how a course that utilizes service-learning and an applied approach to education can aid in the transformation of students from anxious and fearful of communicating with dying patients and their families to individuals who not only look forward to their interactions, but continue to volunteer beyond the completion of the course.

End-of-Life Communication has been offered each spring over the past 4 years with an average enrollment of 25 undergraduate and graduate students per class. Approximately, 33% of the students in each class were either health professions (pre-med, pre-PA, etc.) or nursing students. Nearly 60% of every entering class had not spoken with a dying relative or friend or attended a funeral. This course used a multi-method and combined theoretical and applied pedagogical approach to educate the students about death and dying communication. Three textbooks were utilized: On death & dying (1969); Communication as comfort: Multiple voices in palliative care (2008); and Tuesdays with Morrie: An old man, a young man, and life’s greatest lesson (1997). In addition, Wit (2001) and Randy Pausch Last Lecture (2007) were shown and discussed. During the second half of the semester students spend 20+ extra-class hours volunteering at an inpatient hospice. Their participant-observation work at the hospice served as the data for their final research project. Through their in-
class discussions and serial self-reflection papers (first class, mid-term, and final class) their evolving values, beliefs, and end-of-life communication skills are clearly verbalized. While this course has only been offered to pre-health professions, nursing, and Communication students, it would seem an appropriate approach for training a wide variety of health professionals.

A communication skills curriculum for pediatric residents: update on progress

Authors:
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Introduction/context: We developed a resident communication skills curriculum (RCC) to address the growing emphasis on the importance of effective communication in the medical literature, the ACGME mandate that residents achieve competency in these skills, and the lack of a formal curriculum at our institution. Our purpose is to report on the development, evolution and progress of the RCC.

Description: The RCC was developed by a multidisciplinary committee after a needs assessment confirmed a disparity between resident self-perception of communication skill and the perception of faculty physicians, nurses and ancillary staff. The RCC has evolved into an 18-month rolling curriculum with 9 core didactic topics, videotape review and discussion, a multi-setting simulated experience and observed real clinical encounters and patient handoffs. Evaluative processes include ratings of core didactics, simulated sessions, year-end surveys, graduating resident surveys and post-graduate surveys distributed 1-year after completion of training.

Evaluation/impact: Core didactic lecture are highly rated (3.93/4 on a 4-point Likert scale). The simulated experience has demonstrated a statistically significant change in participants’ self-perception of preparedness, skill, confidence and anxiety (each demonstrating a median 1-point change on a 5-point Likert scale with p-values <.05 by Wilcoxon-signed ranks). 66.7% of responding graduating residents agreed they provided better care and 55.6% agreed they had changed their practice as a result of the RCC. With the coming academic year we will have observed clinical encounter scores for residents over the course of their residency allowing pre- and post-RCC comparative analysis.

Discussion/implications: We have developed a communications curriculum that is integrated into the training experience of residents at our institution. We address basic communication skills as well as the higher-level skills needed to approach difficult communication responsibilities. We have incorporated a multi-step evaluative process that not only rates individual components but assesses the overall real-life impact of the RCC.

Communication intervention for oncology fellows: Interim results of an institutional program

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Introduction: Cancer communication training programs have lacked institutional integration, and thus have not attended to the hidden curriculum. We are implementing a 4-year institutional communication intervention for oncology trainees and studying the impact of the training using the four levels of evaluation described in Kirkpatrick’s model. This abstract reports on our 2-year interim findings.

Methods: 139 Cancer Center fellows and residents have participated in the communication intervention in Years 1 and 2, completing 4-6 modules on topics such as Shared Decision Making, Patient Anger, and Palliative Care. Training includes didactics, exemplary video, and experiential small group work with SPs and co-led by multi-disciplinary facilitators. We examined the impact of the intervention to-date on multiple outcomes, using the four levels of Kirkpatrick’s model, including participant self-report, recorded SP assessments, SP evaluations, recorded clinical interactions, and patient evaluations.

Results: More than 90% of participants agreed or strongly agreed to course evaluation items such as “I feel confident that I will use the skills I learned today.” Paired samples t-test indicated a significant difference (t(993)=-29.89, p<.001) between pre-training (M=3.32, SD=.86) and post-training (M=4.11, SD=.70) self-efficacy ratings. Participants showed significant change in their communication skill usage between pre- and post-training SP assessments in the areas of agenda setting, checking, and information organization (p<.01). SP ratings were significantly higher for participants post-training than pre-training on 13 of 17 items (p<.05). Recorded clinical interactions showed no skill change. In visits with new patients, significant improvement (p<.05) between pre- and post-training was present on three patient-reported items related to empathic communication and questioning.

Discussion: Interim data analyses demonstrate an impact of the communication intervention on trainees’ course evaluations, self-efficacy, and SP assessments. More complex behavioral change of clinical communication and patient outcomes may be more difficult to achieve, particularly with trainees who have limited responsibilities.
Evaluation of an intervention to increase use of a Teachable Moment Communication Process for smoking cessation counseling

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Objective: Informed by previous research on naturally-occurring opportunities for health behavior change, the Teachable Moment Communication Process (TMCP) enables clinicians to leverage patients’ own concerns into a tailored, partnership-oriented and efficient health behavior change discussion. This paper reports the main findings of a randomized trial evaluating an educational intervention designed to train clinicians to use the TMCP for smoking cessation counseling.

Methods: Using a group randomized trial design, community-based, primary care clinicians (n=31) were randomized to either an attention control or the TMCP training intervention. The TMCP intervention consisted of two 3-hour training sessions that included skill practice with simulated patients and coaching. Routine visits with self-reported adult smokers at baseline and post-intervention were audio recorded and coded to determine the frequency with which elements of the TMCP were used by clinicians.

Results: Clinicians in both groups were similar at baseline across all TMCP elements. After the intervention, TMCP-trained clinicians were more often observed advising patients to quit while effectively linking to a patient’s concern (58% vs. 44%, p = 0.01), expressing optimism (36% vs. 3%, p < 0.001), expressing partnership (40% vs. 12%, p < 0.001) and eliciting the patient’s readiness to quit (52% vs. 22%, p < 0.001) than clinicians in the control group. TMCP-trained clinician responses were in greater alignment with patient expressed readiness than control group clinicians (p < 0.001). All analyses adjusted for the clustered study design.

Conclusions: The intervention significantly changed the content of clinicians’ smoking cessation communication in ways that are consistent with the TMCP model for health behavior change. The TMCP approach is acceptable to clinicians and feasible in real world settings. Future analyses will test associations between the TMCP approach and patient-focused smoking behavior outcomes.

Decision-Making

The Discourse Initiating the Decision-Making Process in Palliative Care (Emmanuelle Belanger)

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Introduction: In palliative care, decision-making often involves addressing an impending death. The tendency of both health care providers and patients to delay the decision-making process constitutes a barrier to involving terminally-ill patients in decisions about their care. The question addressed in this research was: How do health care providers and patients initiate the decision-making process in the context of palliative care delivery?

Methods: This qualitative research study combined organisational ethnography and discursive psychology. The field research lasted one year; 18 patients were followed longitudinally through the course of their care. Data were generated through observations and audio-recordings of formal and informal consultations. Data analysis consisted of identifying the discourses that initiated decision-making processes, and the arguments used to justify broaching difficult decisions.

Results: Patients introduced decisions through asking questions about the future or through attributing these concerns to others, such as their family members. Health care providers introduced decisions needing immediate attention, such as symptom control, with a straightforward discourse directly addressing and eliciting patients’ presenting complaints. When decisions entailed discussing the end of life, initiating the decision-making process required a different discourse. This could be accomplished indirectly by probing the patients’ understanding of the disease process, or directly when providing a justification for initiating a difficult discussion, such as expressing concern about the likelihood of complications. Exploring patients and family members’ emotional response also offered an entry into decision-making, which further upheld the acceptability of broaching difficult decisions.

Discussion: It is noteworthy that approaching urgent decisions was part of health care professionals’ taken-for-granted role, while broaching decisions that entailed preparing for the end of life called for justifications. Unlike hypothetical guidelines about end-of-life communication, discursive psychology offers a contextualised explanation of how different discourses achieve rhetorical ends when introducing difficult palliative care decisions.
The implications of the sequential organization of patient-physician communication for informed decision making in discussions about early stage prostate cancer

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Background: Little is known about how patients and physicians communicate during visits in which they discuss treatment options for newly-diagnosed prostate cancer. The sequential organization of communication activities during these visits and how participants communicate during transitions between activities may have implications for informed decision making.

Methods: We analyzed transcripts of 40 urology clinic visits during which 40 patients received new diagnoses of early stage prostate cancer from 18 different physicians to identify major communication activities. We analyzed patient-physician communication during transitions between activities to capture interaction dynamics.

Results:
We identified five communication activities which, in a majority of visits, occurred in the following sequence: “diagnosis delivery,” “risk classification,” “options talk,” “decision talk,” and “next steps.” The first three activities were the same for ≥90% of visits; patients spoke very little during transitions between these activities. Most transitions were physician-initiated. However, patient statements or questions delayed physicians’ attempts to transition out of “options talk” and/or “decision talk” in over one-third of visits. Some physicians explained transition options as their “job.” Four patients initiated transitions into “decision talk” before “options talk” was finished. In all four cases, physicians avoided or minimized “decision talk” until they could finish “options talk.” A minority of patients indicated uncertainty about the overall visit purpose or about who should make treatment decisions.

Discussion: Communication during visits discussing treatments for early stage prostate cancer follows a regular sequence that suggests physicians make thoroughly discussing treatment options a priority but provide minimal opportunity for patients to discuss diagnosis or prognosis. Physicians’ focus on thoroughly describing options fulfills an important requirement for informed decision making. However, patient interruptions suggest a need for discussion of the options and the treatment choice. Absence of patient questions following “diagnosis delivery” and “risk classification” raises questions of adequacy of patient-centered cancer communication.

Decision-Making Behaviors & Sequential Analysis: The Medical Interaction Decision-Making (MIDM)

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Introduction: Many measures of shared decision making focus on overall ratings of physician decision-making and less on the interaction between patient and physician. This presentation will describe the associations between communication behavior in decision-making, the sequences of those behaviors, and ratings of shared decision-making. We report data from the MIDM (Medical Interactions in Decision Making), which codes behaviors associated with decision-making, the relationship between physician behaviors and patients' behaviors, and the sequence that these decisions occur.

Methods: We conducted a study using unannounced Standardized Patients (SPs) to examine physician responses to a consistent stimulus, that is, an actor trained to portray accurately an advanced cancer patient. We obtained 40 recordings for analysis. Episodes of decision-making were identified for each transcript. Physician and patient behaviors and the sequence of these behaviors were coded and scored using the MIDM. In addition, a new set of coders applied the OPTION scale to this data.

Results: Sequential analysis with combined MIDM codes found that the most likely sequences were physician directive behaviors (i.e. recommendations, initiation of topics) followed by patient non-active behaviors (i.e. not initiating topics, not asking questions), and physician engaging behaviors (i.e. asking for patient feedback, offering patient options) followed by patient active behaviors (i.e. asking for clarification, making requests). We will present additional analyses of these data.

Discussion/Implications: The MIDM shows good reliability and validity to recommend it for wider use in physician patient communication research. We found associations between physician and patient behaviors during decision-making episodes and the quality of shared decision-making. When patients interrupt physicians during decision-making and when physicians discuss risks independent observers rated physicians as engaging in more shared decision-making. Patient interruptions and physician risk discussions may be important markers for the openness of physicians to patient engagement in the decision-making process.
Meeting breast cancer patients’ preferences for information in oncology consultations: impact on decision related outcomes

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Introduction/Objectives: Early stage breast cancer patients’ preferences for cancer information vary with some preferring minimal details needed only to facilitate self-care. Little is known about the relationship between whether these varying patient preferences are met and the impact this may have on patient outcomes. We investigated a) patient’s knowledge about their cancer, b) patients’ perceptions of whether their preferences were met and c) the impact of unmet patient preferences on decision related outcomes.

Methods: The international participants were 62 oncologists and 614 early stage breast cancer patients facing a treatment decision. Questionnaires were used to elicit: a) patients’ knowledge about their disease and treatment options, physicians completed a matched questionnaire for each patient, b) patients pre- and post consultation information preferences and c) post consultation decision related outcomes.

Results: Most (83 – 86%) of patients correctly reported disease information but only 41% correctly reported risk of recurrence without treatment. 57% of patients reported that their information preferences were met. 41.2% reported that they received less information than they desired and, of these 93% preferred maximal information. Physician-patient congruence about all available treatment options was only 18%. Decisional conflict was significantly higher for those patients whose preferences were not met (F (3, 592) = 8.85, p < .0002). Decisional satisfaction was significantly higher for those whose preferences were met or exceeded. (F (3, 590) = 8.65, p < .0002)

Discussion: Patients accurately reported some disease information but had difficulty estimating risks of recurrence. Patients and physicians were overwhelmingly discordant about which treatment options were discussed. Most patients’ preferences were unmet resulting in worse decision outcomes. These results underscore the ongoing oncologist-patient communication difficulties experienced during consultations. Oncologists need to: a) elicit and meet patient information preferences and b) ensure patient understanding of information to improve patients’ decision related outcomes.

The implementation of patient decision support interventions into routine clinical practice: a systematic review

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Background: Despite the efficacy of patient-targeted decision support interventions (DESIs), their effectiveness in routine practice has yet to be established and widespread adoption has not occurred. The aim of this review was to identify published peer-reviewed studies that investigated the effectiveness of strategies, methods or approaches to implement patient-targeted DESIs into routine clinical settings.

Method: An electronic search strategy was devised in OVID Medline and adapted for ten databases. In addition, we used a range of “snowballing techniques”. Peer-reviewed publications were considered if they reported on the use of methods to promote the use of patient DESIs in routine practice. Studies were included after dual independent assessment. Independent data extractions were performed. Each study was summarized, and a synthesis of the results was produced. Finally, the level of implementation achieved in each study was rated.

Results: 5322 records were identified, of which 51 were retained after screening of titles and abstracts. After examining full-texts, 17 studies were included and subjected to data extraction. Few studies described an explicit implementation framework as the basis of their evaluations. The approach used in almost all studies was one where clinicians and their staff used a referral model of DESI distribution. There were significant challenges to the implementation of DESIs using this model, ultimately contributing to organizational inertia regarding their adoption. None of the studies indicated that organizations had been able to achieve ‘maintenance’ levels of implementation, where DESIs were in sustained use.

Conclusions: It seems too early to make firm recommendations about how best to implement DESIs into routine practice because approaches that use a ‘referral model’ consistently report difficulties. We sense that the underlying issues that mediate against the use of patient decision support and, more generally, limit the adoption of shared decision-making, are under-investigated and under-specified.
Speaking-for and “speaking-as”: Pseudo-surrogacy in physician-patient-companion medical encounters about advanced cancer

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Introduction: Patients are frequently accompanied by companions during healthcare visits. Studies have drawn mixed conclusions about the outcomes of such accompanied visits. We explored potential causes of this ambiguous research literature by analyzing the moment-by-moment interactions of physicians, patients, and companions in a data set of audio-recorded medical encounters. We were specifically interested in the extent and form of companion participation during discussions of prognosis and treatment choices.

Methods: The data used in this study are from the observational phase of a larger randomized trial that focuses on patients with advanced cancer. From 35 transcripts of accompanied visits, 28 discussions about prognosis and treatment choices were coded for the presence of a specific form of companion participation we termed “speaking on behalf of” a patient.

Results: Our data showed that companions often spoke on behalf of patients during discussions of prognosis and treatment choices. We defined one salient form of this interaction as “pseudo-surrogacy,” which is when a companion “speaks as” a patient by describing the patient’s values, beliefs, or experiences without inviting the patient to participate.

Discussion: Based on our data, we describe a possible spectrum of different forms of speaking on behalf of patients and consider the implications of these companion utterances for patient autonomy and patient-centered care.

Missed opportunity? Caregiver participation in the clinical encounter

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Introduction: Caregivers offer meaningful support to patients by assisting with the workload of self-care for chronic conditions. However, little is known about caregiver involvement during these clinical decision-making encounters. We conducted a secondary videographic analysis aimed to determine how caregiver engagement is influenced by use of decision aids.

Methods: We identified videorecordings from three randomized clinical trials of the Diabetes Medication and Statin Choice decision aids (DA) where the intervention was tested with a healthcare profes-
Developing a medication management information guide for ethnic minority family caregivers of people living with dementia

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Aim: This study aimed to develop an information guide for ethnic minority family caregivers managing medications for their relatives diagnosed with dementia.

Methods: The study was conducted in two stages. The first qualitative stage involved conducting focus group and one-on-one interview discussions to explore the medication management experiences of ethnic minority family caregivers caring for relatives living with dementia. This stage of the study was conducted over a four month period between July-October 2012 in Australia. The major themes derived from the qualitative data were then used to inform the development of the medication management information guide (the second stage of the study).

Results: The major themes which emerged from the qualitative data (stage 1) included: managing medication is a common source of stress exacerbated by the care recipients' cognitive decline; family caregivers often use strategies to avoid conflict when the care recipient refuses to take their medication(s); and family caregivers find it difficult to source information and/or support about medication management issues, which can be complicated by limited English proficiency. These themes, in addition to several aspects about how to manage their relatives' medication(s) safely are currently being developed into an easy-to-understand online talking book resource, which will also be available in hard copy and on DVD. For initial evaluation purposes, the resource will only be made available in English and Italian. It is anticipated however, that over time the resource will be available in several different languages.

Conclusions: To date, very little information has been available in terms of resources for ethnic minority family caregivers trying to manage medications safely and effectively for their relatives living with dementia. This study is important because it has contributed to the development of a resource which will be able to address this situation.

Health System and Interprofessional Communication

Qualitative assessment of referral letters of patients with chronic fatigue and a psychiatric disorder

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Introduction: Care delivery is a complex process, involving many different actors. Appropriate communication between those actors is of key to guarantee qualitative and thus safe care. Referral letters are one of the most important means of communication between care providers. The aim of this study was to perform a qualitative assessment of the content of referral letters (second to first level providers) of patients with chronic fatigue and a psychiatric disorder.

Methods: The study was conducted at the department of General Internal Medicine of Ghent University Hospital. Based on a comprehensive search of the literature, a checklist of respectively 24 quality indicators was developed assessing the content and way of interdisciplinary communication between second and first level providers. Indicators were considered as dichotomous variables (present/absent). All referral letters (June 2010-February 2011) of 126 patients with chronic fatigue and a psychiatric disorder were considered.

The study cohort consisted of 108 (85.7%) females, mean age was 39.3±11.1 years. Of the 24-item checklist, on average 18.7±2.1 of the indicators were present. Telephone number of the referring physician was never included 0% (0/126), reason of initial referral was not mentioned in 96% (121/126) of the letters. Information about allergic status was missing in 42.9% (54/126), current medication in 96% (121/126), surgical and medical history in 34.1% (43/126) and 9.5% (12/126) of the cases. Psychosocial information was not included in 22.2% (28/126) and 63.5% (80/126) of the letters did not mention the dates investigations were performed. Average time-delay between consultation with secondary care provider and sending the referral letter was 44.2±47.7 days.
Factors Associated with Primary Care Physicians’ Use of Patient-centered Communication

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Introduction: Patient-centered communication, such as supportive talk or partnership building, is considered central to high-quality healthcare. How environmental factors, such as electronic medical records (EMRs), patient written reminders, and health risk appraisals (HRAs), may foster or inhibit clinicians’ use of patient-centered communication is not known.

Methods: Observational study of N=485 periodic health examinations in primary care. Patients were due for colorectal cancer screening at time of audio-recorded office visit with a study-participating physician (N=64). Patient characteristics were obtained via pre-visit surveys, and physician characteristics from administrative records. Office visit audio-recordings were coded for self-initiated physician use of partnership building and supportive talk (Street, 2001). Research observers noted environmental factors. A structural equation model, that considered the nested data, was fit to estimate association of personal and environmental factors on physician use of partnership building and supportive talk.

Results: Mean patient age was 59 years, 65% women, 28% black, and 9% endorsed depressive symptoms; mean physician age was 50 years, 57% women, 14% black, and 68% general internists; 81% of visits had EMR use, 13% an HRA, and 11% a patient written reminder. Physician use of supportive talk was positively influenced by patients having depressive symptoms, physician age, and HRA use, and negatively influenced by patients having a written reminder. Use of partnership building was positively influenced by patients’ educational attainment, and black race, and negatively influenced by physicians’ black race, and patients having a written reminder and recently having seen physician.

Discussion: Model results support the importance of personal physician and patient factors as well as contextual influences, particularly HRAs and patient written reminders, on physicians’ use of supportive talk and partnership building. The impact of commonly present environmental factors on office visit communication quality needs to be monitored for both positive and negative consequences to patient-centered communication.

Communicating about the research activities developed in a hospital might increase patient satisfaction, and hospital’s attractiveness

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Introduction/objectives: Having access to clinical trials and investigational drugs and procedures may be regarded by patients as an attractive feature. However, medical research can also be negatively perceived by patients who are afraid of being used for experimental purposes. The objective of this study was to investigate patients’ perception of the research activities conducted in a comprehensive cancer centre.

Methods: A postal survey (n=745) was conducted on adult patients 6 to 25 months after their diagnosis of colorectal, breast cancer or hematological malignancy at a French regional comprehensive cancer centre.

Results: 574 patients responded (77%). They were on average 58 years old (SD=14) and 7% previously participated in a clinical trial. 51% of the respondents declared that their knowledge of research activities conducted at this hospital influenced their decision to attend this institution and 75% declared that the existence of research activities is certainly an indicator of high quality care. Most of the patients (86%) said they would recommend the hospital to friends and relatives. This response was more frequent among patients who associated research activities with high quality care (adjusted odds ratio [aOR] = 2.4, 95% Confidence Interval = 1.3 to 4.6), and less frequent among those (30%) who said they had never or not often enough been asked to participate in research (aOR = 0.5, 95% CI= 0.3 to 0.96), whatever their previous clinical trial participation (aOR = 3.0, 95% CI= 0.6 to 15.1), socio-demographics, cancer characteristics, and satisfaction with care.

Discussion/implications: The cancer patients from a single institution surveyed here had a positive image of medical research and the “research climate” in the hospital was positively perceived even when patients did not themselves participate in a trial. Communicating about the research activities developed in a hospital might increase patient satisfaction, and hospital’s attractiveness.

Workplace learning in primary palliative care - a baseline measurement

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Introduction: Interprofessional collaboration in healthcare entails learning from, with and about each other. Palliative care is a good example to study interprofessional collaboration. In Belgium, family physicians (FPs) often rely on nurses from specialist palliative home
care teams (PHCTs) in caring for their palliative patients. This leads to workplace learning (WPL) for FPs, which is partially implicit (without explicit learning intention). We aim to describe what, how and from whom FPs learn through collaboration.

Methods: Cross sectional study in the Dutch speaking part of Belgium. Family physicians and PHCT nurses filled in online questionnaires about ‘what’, ‘how’ and ‘from whom’ they have learned during their collaboration. Other questions involved nurses’ style of giving support and advice to FPs.

Results: Participants were 243 FPs, and 72 PHCT nurses.

Topics learned by FPs (mean 6.6, SD 6.4) focused on physical and psychosocial items, less on teamwork and organizational issues. Topics learned by PHCT nurses (mean 3.8, SD 5.5) were predominantly psychosocial.

The learning activities most mentioned were ‘observation’ (37%), ‘discussion’ (25%) and ‘asking questions’ (13%). ‘Receiving feedback’ (6%) and ‘learning from mistakes’ (1%) were the least mentioned. Both nurses and FPs learned mostly from the patient and his family (48%). Secondly FPs stated to learn from PHCT nurses (29%) and nurses from FPs (17%).

Nurses stated to be informative and emotionally supportive towards FPs who perceived nurses to behave mostly prescriptive (30% match of style perception).

Discussion/Implications: Workplace learning is a reciprocal activity. The learning involves predominantly patient-related topics and less team-based topics. Nurses and FPs develop a range of learning activities. The meaning of the differing perception of nurses’ interprofessional style is not clear. The quality of interprofessional relationships is important for WPL and this requires further research.

Healthcare Professionals
Residents’ Likelihood of Speaking Up About Traditional and Professionalism-Related Patient Safety Threats

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Background: Patient safety experts advocate assertive communication, but residents’ position in the medical hierarchy may hinder speaking up. We sought to: (1) determine the likelihood and content of residents’ speaking up about traditional versus professionalism-related safety threats and (2) develop a tool to measure residents’ perceptions of the speaking up climate and its association with speaking up in the clinical learning environment.

Methods: We surveyed 732 medical and surgical residents across two large academic hospitals. The questionnaire included Vignette A (traditional safety threat) depicting a physician forgetting to wash his/her hands after examining a patient with C. diff infection; Vignette B (professionalism-related safety threat) depicting a physician distracted by texting on their phone during rounds in the ICU; several validated safety climate scales; and a newly developed speaking up climate scale (score range: 8-40, Cronbach α=.85). Higher scores represent environments more conducive to speaking up. We used McNemar test to compare residents’ responses to each vignette and logistic regression to assess the relationship between safety climates and speaking up.

Results: Data collection is ongoing. After one request, 172 (23%) residents responded. Residents were more likely to report speaking up in Vignette A (traditional safety threat) than Vignette B (professionalism-related safety threat) (56% vs. 9%; P<.001) and reported using more assertive language in Vignette A than Vignette B (28% vs. 8%; P<.001), despite perceiving the potential for patient harm to be high or very high in both vignettes (35% vs. 32%; P=.57). The speaking up climate score was significantly associated with speaking up in both Vignette A (OR 1.11, P<.001) and Vignette B (OR 1.14, P=.01).

Discussion/Implications: Residents may not feel comfortable speaking up about threats to patient safety, especially professionalism-related threats. Cultivating learning environments, curricula, and instruments to foster and measure a culture of speaking up may improve patient safety.

Comparison of Physicians’ Responses to Medical Error

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Introduction/objectives: In the 20 years since the “Heart of Darkness” study portrayed the emotional response of physicians in the wake of medical error, changes have occurred in individual and institutional responses to a mistake. Peer support, disclosure and apology, and movement away from “blame and shame” are meaningful improvements. In this work, we compare the coping experiences of physicians involved in a serious error, those whom we identified as exemplars, to non-exemplars.

Methods: This work is part of a mixed-method investigation, studying both physicians coping with a serious medical error and patients coping with chronic pain. Investigators interviewed 68 physicians who had been involved in a serious medical error. During in-depth interviews, we asked physicians to share their story of coping with a medical error, including what helped and hindered their journey through this difficult experience. We have previously reported an analysis of the exemplar narratives to illustrate a “path to wisdom through adversity” following a serious medical error.

Results: We categorized 75% of the physician narratives as exemplars in terms of coping and growing through adversity. The changes that exemplar physicians described closely parallel Ardelt’s definition of wisdom: increased compassion, understanding the limits of their knowledge, humility, ability to tolerate ambiguity an appreciation of complexity. Their responses included practice changes, sharing their
OpenNotes: How Do Shared Visit Notes Affect Trust and Transparency in the Patient-Doctor Relationship?

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Background: In the OpenNotes project, doctors invited patients to read their visit notes online. While safety experts and patient advocates encourage transparency, critics worry that shared notes could harm patients and promote defensive medicine. Errors in notes, inaccurate portrayal of the visit, or offending comments could damage the patient-doctor relationship. We wondered: would OpenNotes bring doctors and patients closer together or farther apart? Would patients speak up about concerns in their notes? Would doctors worry about liability?

Method: 114 Primary care physicians volunteered to participate, inviting about 20,000 of their patients to access visit notes over secure Internet portals in 3 sites: an academic medical center (Boston, MA), a rural health system (Danville, PA), and an urban safety-net hospital (Seattle, WA). We analyzed the post-intervention surveys of 99 doctors and 5013 patients who had at least one visit in the study period.

Results: After reading their notes, nearly all (99%) patients felt better (43%) or the same (56%) about their doctor. Few (10%) patients reported contacting their doctor about concerns in their note; of those, 22% reported a perceived error, and 88% were satisfied with the resolution. Of participating doctors, 0% reported ordering more tests or referrals, and 2% worried that shared notes would increase liability. After a year, 54% doctors believed shared notes increased patient satisfaction; 53% believed patients trusted them more (an additional 19% reported “don’t know”).

Discussion/Implications: Despite concerns about decreased trust as a result of reading or finding errors in notes, OpenNotes didn’t make patients feel worse about doctors, and 43% felt better about their doctor. Over half of doctors believed the intervention increased patient trust and satisfaction. Although few patients contacted their doctor, perceived errors were a common reason for doing so, highlighting an opportunity for education, patient-reporting tools, and patient safety enhancement.
Communication - Descriptive Analysis

Doctor-Patient Communication on a Hospitalist Service: Types of Conflict

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Introduction/objectives: Barriers to doctor-patient communication are frequent and can impede care. Interpersonal conflict can give rise to such barriers. Conflict described in the outpatient setting has often been found to be implicit, not openly expressed by the patient. Descriptions of doctor-patient conflict in hospitals are lacking. We classified types of conflict through analyzing doctor-patient dialogue on a hospitalist service.

Methods: We audio-recorded dialogues between doctor and patient on an academic hospitalist service each day of the patient’s hospitalization, as well as daily interviews conducted separately with patients and their hospitalists. Interviews were transcribed and then broadly coded by two internists with attention to noteworthy elements of the hospitalization involving conflict either explicit or implicit between doctor and patient.

Results: We audio-recorded 24 patient-doctor dialogues, representing 18 separate patient hospitalizations, as well as 24 corresponding interviews with hospitalists and 24 interviews with patients. The total recording time was 558 minutes. Of the 18 hospitalizations, we noted significant conflict in 8. Types of conflict here are not mutually exclusive. Informational conflict occurred when the doctor gave either too much (N=1) or too little information (N=4) for the patient about disease process or plan of care. In 2 cases, patients expressed dissatisfaction at a change in the plan of care that they did not know about. Disagreement with the plan of care was noted in 3 cases. Discharge conflict (N=2) occurred when the patient was dissatisfied with the criteria for discharge or the relevant arrangements. In one case, conflict between patient and physician was connected to an unwanted physical examination.

Discussion/implications: Conflict in the hospital is not infrequent and might be classifiable into a limited number of types which should be explored by future work.

Parent-Initiated Dialogue about Medications during Family Centered Rounds

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Introduction/objectives: Experts suggest engaging parents in the care of their hospitalized child to improve medication safety. Family centered rounds (FCR) provide an opportunity for parents to initiate dialogue about medications. Understanding and anticipating common parent-initiated dialogue around medications could facilitate effective FCR. We sought to describe and quantify medication-related dialogue initiated by parents during FCR and healthcare team responses to such dialogue.

Methods: Three trained coders analyzed a total of 81 FCR videos for 49 families of children on our hospitalist, oncology, and pulmonary services. Pairs of coders identified and sorted parent-initiated medication dialogue into mutually exclusive descriptive categories for 1) type of order (new order, active order, missing medication, or home medication), 2) medication therapeutic class, and 3) a topic descriptor (e.g., frequency and duration or the drug indication). Coding of the healthcare team responses included 1) response type (e.g., deferring a response or providing information) and 2) action taken (e.g., changing the treatment plan). Discrepancies were resolved by consensus.

Results: Parents initiated dialogue about 144 medication topics within 62 (77%) of the 81 FCR videos. Parents most frequently raised topics related to active inpatient medications (50%), while medications for home use comprised another 24% and potential new medications were 22%. Anti-infectives (41%) and analgesics (29%) were the most common medication classes raised by parents. Frequent topics included medication frequency or duration (23%), indication (12%), or route (11%). Among healthcare team responses, 69% involved providing information for the family, 4% deferred the discussion, and 9% resulted in a change in the treatment plan.

Discussion/implications: Parent-initiated dialogue about medications occurs in most FCR sessions and can influence treatment plans. Preparing the FCR team to address medication use at home and specific types of issues (e.g., frequency or duration) for commonly discussed medications such as anti-infectives and analgesics could facilitate these discussions.
Exchanging Patient Resistance as Active Participation during Clinical Interactions

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Introduction: Patient-physician clinical communication concerning proposed treatments for pain relief can be difficult for both patients and physicians. While these clinical encounters are often challenging, they may offer an opportunity to examine how patients participate actively by enacting their rights not to accept a treatment recommendation. Using a resistance theoretical framework, this study examines a type of active participation by patients that includes passive and/or active resistance of treatment recommendations, which may allow a mutually acceptable treatment plan to emerge (Koenig, 2011). The purpose of this study was to examine the process by which a patient employed resistance strategies in order to influence the outcome of a clinical interaction concerning pain management.

Methods: This interaction was selected from a larger archive of videos depicting clinical interactions with African American patients in an urban low-income clinic. The chosen interaction clearly illustrates the role of patient resistance in the negotiation process. This case study uses discourse analysis and a resistance framework to examine the transcript of one video recorded clinical encounter in which a patient with knee pain and a primary care doctor disagreed about management.

Results: The patient employed the following passive and active resistance strategies during the negotiation of treatment: 1) silence, 2) requesting explanations for the physician’s recommended treatment, and 3) explicit rejection of the physician’s recommended treatment. The patient’s negotiation strategies also included descriptions of his economic disadvantage and his previous failed attempts to find a successful treatment plan for his pain. These patient negotiation strategies ultimately led to a collaboratively co-constructed and mutually acceptable treatment plan.

Discussion/Implications: Physicians should be prepared to acknowledge patient resistance as an attempt to negotiate. The process of can serve as a tool for understanding the context of the patient’s illness and motivation for endorsing proposed treatment plans.

Communication Outside of Primary Care

How Structured are Pharmaceutical Interviews? Illustrating Variance in Diabetes Care

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Introduction/objectives: Portuguese community pharmacies were reimbursed by the government, from 1998 to 2009, to provide diabetes care. This advanced service comprised activities such as point-of-care measurements (e.g. blood testing) and therapeutic follow-up, in a consultation environment. The aim of this study was to explore present pharmaceutical interviews aim, duration and structure from pharmacies still offering diabetes-related services.

Methods: From a government database, pharmacies previously with high and low diabetic patients output, country wise, were invited to participate if diabetes blood testing was systematically provided. After informed consent, interviews were taped and scanned in relation to consultation aim & content, segments and length.

Results: From 60 diabetes interviews, 9 (15%) were purposively selected to illustrate consultation variance, from a normal segmentation and sequence (opening → history → exam/blood testing → counselling → closing) to a complex interview structure, where segments progression was unclear. Interviews were classified as: simple parameters measurements (SPM), medication use review (MUR) and therapeutic outcomes assessment (TOS), varying from 2min:34sec to 46min:22sec long (16min:28sec on average). Consultation segments were not always present (e.g. opening) and their duration varied from 0min:16sec to 19min:01sec (history), 1min:18sec to 15min:27sec (exam i.e. blood testing) and 0min:09sec to 21min:32sec (counseling). Interview and segment duration were associated with aim & content (SPM < MUR < TOS).

Discussion/Implications: The missing opening is explained knowing patient contact is usually initiated at the pharmacy counter. Although interviews comprised the same exam procedure, there were significant variations in segments length and sequence. The variable structure is explained through interviews’ aims & contents, though also depending on exams’ results - undesirable values triggered new history and/or counseling segments. In any case, knowing pharmacists’ care is grounded on patient information and education, longer counseling segments were expected. Patient interview training is needed for those pharmacists still performing diabetes care in Portugal.

Interactions between Speech-Language Therapists and Significant Others of Aphasic Stroke Survivors in the Context of Rehabilitation

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Introduction: Significant others of stroke survivors with aphasia- an associated language disorder- are usually included in rehabilitation and in speech-language therapy. They also experience changes in communication with their loved one who has aphasia. Clinical experience suggests that significant others are often satisfied with rehabilitation and speech-language therapy services. However, research evidence indicates that significant others encounter challenges after the person with aphasia has been discharged. The project aimed to understand how significant others and speech-language therapists viewed one another in rehabilitation.

Methods: 12 significant others of aphasic persons and speech-language therapists were individually interviewed. Data were analysed with a grounded theory approach.
Use of Thematic Analysis to Explore Team Effectiveness in Veterinary Practice

Authors: Irene Moore, University of Guelph

Introduction: Research in the human health field has shown that successfully functioning teams with effective communication lead to improved quality of care resulting in improved patient outcomes (e.g., reduced post-operative pain, improved post-operative functioning, decreased hospital stay, improved patient ratings of care) (Gittel et al., 2000), and improved job satisfaction (Gittell, 2008). Conversely, research in human medicine has shown that medical errors are often a result of miscommunication within malfunctioning healthcare teams (Kohn et al., 2000). Although communication problems with colleagues and staff also contribute to decreased job satisfaction for veterinarians and veterinary technicians (OVMA, 2004; Figley and Roop, 2006), research into the function of veterinary healthcare teams and their impact on patient outcomes is limited.

Methods: To begin exploring the concept of the healthcare team within companion animal practice, an inductive research approach was used to investigate the unique perspectives of veterinary technicians and veterinarians. In 2009, four focus groups of veterinary technicians (n=27) and four focus groups of veterinarians (n=23) were conducted to explore their independent perspectives of the veterinary healthcare team. Thematic analysis, a qualitative research method, was used to develop themes and subthemes, to elucidate each group’s perspectives on factors which either enhance or impede barriers to optimal team effectiveness within veterinary practice. The overarching theme in both sectors was communication, with other emerging common themes including leadership, coordination, toxic attitudes and environment, and work engagement. Implications for veterinary practice are discussed.

Preliminary results: Interactions between participants had a focus on the person with aphasia. Following stroke onset, significant others centered themselves on their loved one, perceived as vulnerable. Speech-language therapists focused on the aphasic person, their client, to facilitate recovery and the use of communication strategies. Both groups of participants influenced one another to jointly center on the aphasic person. Even though significant others were satisfied with this alignment, they reported difficulties in communicating with the aphasic person after discharge from rehabilitation. Speech-language therapists did not discuss communication adaptations with family members because they believed family members were still hoping for complete language recovery.

Implications: Frank conversations combining realism and hope for the future might better prepare family members in adjusting to aphasia and improve professional satisfaction for speech-language therapists.

Patient-Pharmacist Interactions: Assessment and Education for New Prescriptions at the Independent Pharmacy Counter

Authors: Lisa Guirguis, University of Alberta
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Introduction: Pharmacists’ roles have been evolving from dispensing to assessing the appropriateness of medication therapy and educating patients. Patient-pharmacist interactions can resolve drug-related problems, empower patients to adopt positive self-management strategies, and increase patient satisfaction. Appropriate pharmacist-patient communication is important in achieving these patient care aims.

Objectives: Characterize pharmacists’ and patient’s role in therapy assessment and education with prescription medications.

Methods: A convergent parallel mixed method design was used. Independent pharmacies were purposively recruited. Pharmacists identified eligible patients who were: 18 years of age or older, receiving at least one new prescription medication and able to provide consent. Pharmacist-patient interactions were audio recorded. Quantitative statistics characterized question asking, the content and processes of assessment and education. Qualitative methods, specifically Interpretive Design, were used to identify key codes and themes in the patient and pharmacist interactions.

Results: Twenty-seven audio recordings from eight pharmacies were analyzed. In 66.7% of interactions, pharmacists used a similar structure: share information on the medication purpose, drug instructions, and side effects. Pharmacist conducted minimal assessment about patient’s current condition and medication history. Pharmacists asked “Any questions?” in 37.0% of recordings and open-ended questions in 33.3%. In 7.4% of interactions, pharmacists asked leading questions, typically on directions. Pharmacists rarely assessed patient understanding; although patients asked for clarification in 33.3% and performed a spontaneous teach-back method in 22.2% of interactions. Four qualitative themes were identified: Pharmacist Monologue, Patient Resistance, Missed Cues, and Spontaneous Teach-Back Method.

Discussion: Patient-pharmacist interactions focused on pharmacists providing medication information, often in a structured format. Pharmacists rarely assessed patients’ history, infrequently invited patient questions and in a few instances, missed cues about patient concerns. Patients participated by asking questions and performing spontaneous teach-back method.

Implications: Future research should explore pharmacists and patients’ understanding of their interactions with a new prescription.

Preliminary results: Interactions between participants had a focus on the person with aphasia. Following stroke onset, significant others centered themselves on their loved one, perceived as vulnerable. Speech-language therapists focused on the aphasic person, their client, to facilitate recovery and the use of communication strategies. Both groups of participants influenced one another to jointly center on the aphasic person. Even though significant others were satisfied with this alignment, they reported difficulties in communicating with the aphasic person after discharge from rehabilitation. Speech-language therapists did not discuss communication adaptations with family members because they believed family members were still hoping for complete language recovery.

Implications: Frank conversations combining realism and hope for the future might better prepare family members in adjusting to aphasia and improve professional satisfaction for speech-language therapists.
Intake of New Patients in Private Second-line Periodontal Care

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Introduction: The first visit of a patient requires professional multitasking. Dentists have to attend to patient’s wellbeing, review medical/dental history, collect clinical data, communicate treatment plan and personal questions. Motivational interviewing (MI) is known to relax anxious patients, but whether it is a feasible technique remains to be investigated. The aim was to compare MI with our standard intake protocol and with an alternative approach.

Material & Methods: 90 new patients consulting a specialist clinic for periodontal disease were randomly and equally divided into 3 groups. A standard protocol group (SPG) completed a questionnaire about medico-dental history. A MI group (MIG) additionally watched a video containing different viewpoints towards general and oral health and a favorite questions group (FQG) received a list with 10 dental topics and had to choose 3 most preferred items to discuss during consultation. After the consultation patients were questioned about their experiences.

Results: No statistical difference was found between the groups regarding age, gender, duration of consultation. Except for 3 out of 10 questions no statistical difference was found between the groups concerning patient evaluation. The MIG and the FQG scored significantly better concerning patient’s assessment about the dentist’s approach and expectations for next dental visits than the SPG (p<0,0001), but the SPG evaluated answering the questionnaire least laborious (p<0,0001). ‘Do I have to be worried about dental complications in the near future?’ was pointed as favorite question by 59,1% of the FQG.

Conclusions: The SPG approach was appreciated twice as much as the other groups. FQG was rewarded with the most encouraging quotes. Favorite questions chosen were strictly of personal interest. MI is especially efficient to relax anxious patients but does not seem to be the first-choice approach, at least in second-line periodontal care.

Communication between Patients and Pharmacy Staff about Product Information Leaflets (PILs)

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Objectives: Product Information Leaflets (PILs) are an important source of information for patients regarding their medication, but may give rise to confusion and questions. Patients then will seek clarification, for instance from pharmacy staff. Our purpose was to study to what extent patients question pharmacy technicians about PIL-related issues and how technicians cope with them.

To our knowledge, this the first quantitative study in which pharmacy technicians have been asked to report their experiences with patients addressing them with PIL-related issues.

Methods: A quantitative online survey was carried out in a panel of (785) Dutch pharmacy technicians, with topics on frequency and nature of patient questions, and how respondents could answer them.

Results: Response rate was 39%. Technicians reported that patients ask most PIL-related questions on drug actions, problems with use, side effects, intolerances and during pregnancy and lactation. Main causes for questions were CV, GI or CNS diseases or drugs for these indications. In addition, external factors such as substitution from branded to generic products and mass media messages also gave rise to questions.

Implications: It is recommended that pharmacy staff persuade patients to ask any questions that may come up during medication use. PIL layout and contents should be more standardized.

Health Literacy

Health Literacy and Health Empowerment in the Field of Emergency Department Use

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Objectives: Health Literacy (HL) and psychological empowerment (PE) are important factors in predicting health behavior. Limited HL has been associated with higher emergency department (ED) use (AHRQ, 2011) and based on the Extended Health Empowerment Model by Schulz and Nakamoto, our study aims to investigate the role of HL and PE in unnecessary ED visits.

Methods: Trained doctors proposed a self-administered questionnaire to all patients during two 24-hours periods, one weekday and one weekend, in four older who entered the ED on their own and were given a white or green triage code were approached. White and green codes may be considered improper access because problems are not urgent and could have been treated by general practitioners. We collected data about HL and PE, sociodemographic status, educational level, language, ED visits in the past year and information seeking behaviour (ISB). Respondents who give us the consent were
again approached by telephone within two months after the ED visit to collect data about the results of the ED visit, risk perception and environmental barriers such as access to medical service.

**Preliminary Results:** The survey included 313 patients. Age 18-93 years (M=47.16 SD= 18.437), 50.8% were males and 49.2% were females, 73.2% were Italian. A consistent part (21%) of our sample have limited HL. Exploratory factor analysis will be used to evaluate the interrelationship among the items of the scales used. Since the outcome variable is ordinal logistic regressions will allow to determine the likelihood that persons’ improper ED’s used is based on the predictors identified in the model.

**Implications:** The study will provide useful indications to prevent the inappropriate use of ED because we can plan interventions focus on factors that play a role in the decisions to seek help in an ED

### Patient Provider Communication and Patient Satisfaction: The Impact of a Health Literacy Intervention

**Author:** Kathy Gunkel, Rutgers University

**Introduction:** “Ask Me 3”, a health literacy tool was implemented in one department of a large, urban university’s Student Health Center to address declining patient satisfaction and service utilization. Providers were educated about Health Literacy and the use of “Ask Me 3” to improve the patient’s understanding of their disease, treatment and self-management.

This project examined the relationship of patient/provider communication and patient satisfaction aimed at increasing health literacy without necessitating significant behavioral changes among providers. “Ask Me 3” helped to increase pertinent patient education and knowledge of the disease by helping the providers focus on the salient points of the exam and diagnosis.

Utilization of “Ask Me 3” was implemented in one department of the health center. Patient satisfaction was measured pre and post implementation. Patient satisfaction was also compared to another department where there was no intervention. Providers who implemented “Ask Me 3” were surveyed to assess the use of “Ask Me 3” as part of the clinical visit.

The most important finding of this project is that patient satisfaction was found to be positively correlated with patient’s perception of two communication indicators: 1) the quality of the explanations they received from the providers and 2) receiving information that they will use to improve their health. Data suggest that improved patient/provider communication leads to improvements in patient satisfaction.

### Use of Health Education Videos for Spanish-Speaking Hispanic Patients of Low Socioeconomic Status

**Authors:** Ara Jamasbi

**Abstract:** According to the 2006 U.S. Census, Hispanics comprise 15% of the entire U.S. population and 22.5% of Florida’s population. Yet, despite this tremendous presence, the realm of healthcare has fallen short in addressing this population specifically. With most health education tools (pamphlets, videos, etc) written in the English language and difficult to understand, patients are not properly educated in the management of their common chronic medical conditions. Among other factors, such a downfall contributes to the increased cardiovascular disease risk of Hispanics to non-Hispanics by a ratio of 3:2. Using a series of animated videos narrated in Spanish, provided by the X-Plain Health Education Company, this study tested the health literacy of Spanish-speaking patients of low socioeconomic status seen at the St. Thomas Aquinas free medical clinic in St. Cloud, FL. All twenty-four subjects (15 female, 9 male) watched one of three Spanish-translated animated health education videos about the most common chronic conditions plaguing Hispanics today: diabetes mellitus type II, hypertension, and hyperlipidemia.

Eligibility was determined by age greater than 18 years old, Spanish language fluency, and having one of the three medical conditions mentioned. The study examined the patients’ baseline knowledge of their illness with a pre-test and identical post-test after watching the video. It was predicted that the health literacy of the patients would be greatly improved through the use of the videos, as evidenced by significantly higher post-test scores. The results of the study demonstrated a significant improvement in the pre and post-test scores in the hypertension (mean pre-test= 44.5%, mean post-test = 65.7%, p=0.01) and hyperlipidemia (mean pre-test= 42.9%, mean post-test= 70.4%, p=0.01) groups, but no significant difference between the scores for the diabetes mellitus type II group (mean pre-test= 39.3%, mean post-test= 48.3%, p=0.11). Limitations of the study included a short latency period from the time of the video screening to the administration of the post-test and the lack of sufficient power in the diabetes group, with only 4 subjects compared to the 10 subjects in the other two groups. Another limitation is the lack of long term measurement if health literacy is retained and test items that were too easy or difficult for all subjects.

**Lay Abstract:** Only when a person is capable of understanding the causes and treatment options of their chronic medical condition can they empower themselves to manage their health. The purpose of the study was to validate health education videos screened in Spanish, the native language of the patients, as a means for patients to achieve a better understanding of their chronic illnesses. These videos remedy the lack of health education in free clinics, where sufficient time is not often set aside to inform patients about their illnesses and their management. The study found that showing Spanish-translated health education videos to Hispanic patients with low literacy and socioeconomic status was associated with significant increases in knowledge about hypertension and high cholesterol, but not with diabetes mellitus type II.
German Adaptation of a Short Instrument for Assessing Health Literacy in Surveys

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Introduction: Low health literacy is associated with numerous adverse outcomes, for example lower health-related quality of life and higher health care costs. As yet, there are only a few studies on health literacy in Germany, among other things due a lack of German instruments for questionnaire-based assessment. In this paper the German adaptation of three items for the assessment of health literacy (Chew et al. 2004) is psychometrically evaluated.

Methods: The psychometric properties of three items often used for detection of low health literacy in the international literature are evaluated on a sample of 398 newly-diagnosed patients treated in German breast cancer centers in June and July 2012. Factor analyses and structural equation modeling were used for assessing the psychometric properties of the instrument. A path model linking health literacy to physical and emotional functioning and the patients’ perception of admittance processing and the amount of information received is estimated.

Results: The extracted factor explains 72.9% of the total variance, Cronbach’s α of the resulting scale is 0.81. The structural equation model shows the expected strong direct relationship between health literacy and health-related quality of life and weaker, but statistically significant relationships between health literacy and admittance processing and the amount of information received. The global model fit of the structural equation model is satisfactory, the threshold for an acceptable model was achieved without further model adjustments.

Conclusion: The use of the three translated items as a tool for assessing health literacy is recommended in self-assessment questionnaires.

Despite my Doctor’s Advice, I Stopped my Asthma Medicine Because I Don’t Have Symptoms Anymore: Patients’ Judgment Skills a Critical Dimension of Health Literacy

Authors: Ana Maria Moreno Londoño, University of Lugano
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Introduction: Health literacy when considered as a multidimensional concept supplies a broader understanding of individuals’ health behavior, thus, contributing to design better health communication strategies to enhance these behaviors. The Health Empowerment Model (Schulz & Nakamoto, 2013) propose judgment skills (JS) as a composite of health literacy. These skills indicate individual’s abilities to use health information in diverse situations.

Objective: To assess the performance of a developed tool assessing JS on the context of asthma self-management.

Methods: 64 asthma patients were recruited in the Italian part of Switzerland. Patients responded to a self-reported questionnaire containing 5 sections, including screening health literacy (HL) questions, 19 scenarios assessing judgment skills, a scale measuring asthma control, and questions concerning asthma self-management, medical history and demographics.

Results: The age range of participants was from 20 to 80 years old, 67% were females. The mean of years suffering from asthma was 25. Only 8% of patients had their asthma completely under control, whereas 50% had uncontrolled asthma. Participants were allocated in one of three groups according to their judgment score, 14% belong to the Low group, 66% to the Medium, and 20% to the High. Lower scores were assigned to poor judgments regarding self-management practices. Preliminary analysis indicate significant differences between groups for the Low and High judgment groups (F=6.25, p<0.015) and (F =5.19, p<0.026) respectively, regarding past behaviors on having enough medicine before the last finished. Furthermore, the High judgment group significantly differed from the others concerning going to their physician when having some problems with their asthma (F =6.9, p<0.01). Finally, 6% of the patients have inadequate HL, 19% marginal HL, and 75% adequate HL.

Conclusion: The results indicate that there is a good evidence for using this tool to assess patient information use in relation to asthma self-management.

Implications: The present study offer a potentially useful measurement tool for a more advanced health literacy level. The findings of this study suggest that measuring the JS of patients can help identify self-management practices that are being carried out ineffectively, and thus can be enhance and corrected through health communication strategies, and doctor patient communication.

Patients Communicating with their Primary Care Physician about Chronic Disease Treatment in Regional Australia: Is Health Literacy Important?

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Background: In Australia, about 7 million people have at least one chronic condition. Diabetes and hypertension are included amongst chronic diseases responsible for more than half of all potentially preventable Australian hospitalisations1. People with poor health literacy skills have difficulty knowing when to seek appropriate health care, and as a consequence experience a high incidence of poor health outcomes, adverse events and hospitalisations.2,3

Aim: The aim of this study was to investigate whether level of health literacy was important in the ways that patients and doctors communicate about chronic disease treatment. The focus of the study was diabetes and hypertension and the population studied were adults
living in regional New South Wales, Australia. This study is part of an international collaboration with University of Montreal Medical School.

Methods: Forty patients with a history of chronic diabetes or hypertension were included in the study. The patients attended one of two different Australian primary care community practices. They were administered the Newest Vital Sign (NVS) health-literacy screening test and the Patients’ Experience of Care survey. Data were analysed to explore the associations between health literacy, as assessed by the NVS test, and patients’ perceptions of chronic disease treatment discussions with their family physician, as assessed by responses to one section of the Patients’ Experience of Care survey.

Results: This study will be completed by April 2013. Results and analysis will be presented at the 2013 ICCH conference.

Discussion: Poor health literacy can lead to poor health outcomes and increased hospitalisation rates. How doctors caring for patients with chronic conditions identify those with poor health literacy skills and communicate with them to provide effective medical information is unknown. Investigating this issue can help us develop appropriate communication strategies for doctors caring for these ‘high risk’ patients.

References:

Results: A preliminary analysis of the data suggests that poor health literacy does result in a poorer understanding of the safe use of the NSAIDs, which could potentially lead to these participants experiencing severe adverse events. Final analysis of the complete dataset will be presented during the ICCH 2013 proceedings.

Discussion: Results of the research will add to knowledge about the use of NSAID medication use in the community setting, as well as insight into patient understanding of correct dosages, management and side effects associated with these medications. Further, the results may identify associations between health literacy and use or misuse of these medications, which will help to inform the quality use of OTC medicines, the development of policy relating to supply of NSAIDs and the provision of accurate information about safe and effective use (if required).

Health Systems and Interprofessional Communication

Becoming Preceptor, Becoming Student: Private Practitioner-Medical Student Relationships in Medical Education

Author: 
Meredith L. Clements

Introduction: Medical schools, like many institutions, are complex and evolving organizations. Over the late 20th and 21st centuries, we have seen deliberate changes in medical education, including efforts to introduce and enhance mentoring in the clinical setting. Founded 12 years ago, Florida State University College of Medicine’s (FSU COM) differs from traditional academic health centers, placing an emphasis on non-traditional methods of clinical instruction. By employing private practitioners to serve as preceptors, FSU COM de-centers the third-year clinical experience, arguing against the notion that training should occur in large teaching hospitals primarily under the instruction of residents and faculty. Examining the mentor-mentee relationship from the perspective of those who experience it broadens our understanding of teaching dynamics as well as the relational process as a whole. Therefore, I ask, how do private practitioners and third-year medical students at Florida State University College of Medicine understand and describe their preceptor-student relational dyads? Additionally, why do private practitioners become preceptors, what do they perceive as incentives, and what motivates them to maintain this role?

Method: In order to explore the experiences of third-year medical students and preceptors, I employ a case study methodology, which fits well with an analysis of individual and dyadic experiences (Le Dorze et al., 2009). Data were collected from both preceptors and students on a daily basis using electronic journals over the course of the six-week rotation.

Findings and Implications: There exists an evolving logic to the preceptor-student relationship that applies across various sorts of instances: to doctor-patient interaction, reading assignments and outside research, and one-on-one discussions of treatment plans. There are few formal rules or expectations, so participants rely on self and one another to formulate a logical structure, or set of rules and roles, that drive the relationship.
Transforming Communication using Appreciative Practices

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Introduction: Incivility is not always obvious. Sometimes it is subtle yet interferes with establishing a culture of trust, respect, and integrity—all necessary ingredients in today’s healthcare education environment. “Seemingly inconsequential ...words and deeds” promote negative emotions and create a hostile environment that interferes with quality care. Work place cultures that tolerate such behavior risk low morale, high turnover, and poor outcomes.

Innovation: The innovative, team building, Appreciative Inquiry (AI) method was adopted at one University Health System School of Nursing as both the philosophical and everyday strategy. All faculty, staff, and community stakeholders were included in the 4-step, AI process of discovering, dreaming, designing, and creating the school’s ideal future. Starting with a retreat during which facilitators from the School of Medicine role modeled appreciative communication and respectful dialogue, constituent participants asked each other positively worded questions that created the foundation of a strategic plan. The final plan included three goals, one of which focused on fostering well-being and collegial spirit. To achieve this goal, volunteers began engaging in appreciative activities to identify what a healthy work environment would look like. Thus, the Healthy Work Environment volunteers began the process of achieving the ideal.

Impact: Four years later, the strategic plan has been approved by all faculty, staff, and representative constituents. Faculty and staff approved a statement describing 32 behaviors that are expected by individuals employed by the school. Twelve faculty members have left. Six new members have been hired. Dialogue continues daily between and among employees about how to improve work relationships and increase collegiality.

Discussion: AI is not well known in healthcare and education, yet is a powerful method to change dialogue and foster healthy work relationships and environment. One university health system is using this process to transform the culture.

Using Continuous Improvement to Improve Patient Satisfaction: A Consultative Approach

Authors: Mary Hays, University of Alabama in Huntsville
Sampson Gholston, University of Alabama in Huntsville

Introduction: With the ever-increasing emphasis on patient safety, this presentation outlines an evolving joint partnership between academia in nursing and engineering. The goal is to introduce industrial and systems engineering graduate students into a hospital setting to explore patient quality measures, using a Lean Six Sigma approach.

Practice Innovation: This year-long project involved collaborating with a hospital in the southeastern United States to examine three years of safety events. The joint effort began with faculty from the College of Nursing and Engineering exploring the placement of master’s level engineering students within a healthcare environment. Their goal was to use the principles of Lean Six Sigma previously applied only in classroom projects. Discussions with the hospital confirmed that they were especially interested in determining which patient safety areas needed further development to sustain the high performer status on the Joint Commission’s Key Quality Measures. The project then expanded to incorporate the hospital’s nursing administration and staff into more efficient use of the continuous stream of daily and monthly trended data.

Evaluation: A weekly program evaluation allowed consultation, assessment, and reassessment of academic and clinical program goals plus individual hospital preceptor and student needs. Effective execution depended on attentiveness to corporate requirements and accommodating scheduling adjustments with the hospital’s nursing leaders. As the program evolved with the increased visibility of the students and preceptors, staff became more accustomed to clarifying information, asking questions, and proposing creative improvements.

Discussion: This consultative approach motivated the clinical and academic environments to further the application of a Lean Six Sigma approach, establish improvement areas, and implement solutions to strengthen patient safety. This format can be a standard for initiating an interdisciplinary course for master’s level nursing and industrial systems engineering students, who will bring an integrated, applications-oriented approach to health care environments, thus improving clinical outcomes.

Student Attitudes Toward Interdisciplinary Team-Based Care: Can an Embedded Interprofessional Education Activity Make a Change?

Authors: Carol Hermansen-Kobulnicky, University of Wyoming
Mary Anne Purtzer, University of Wyoming Fay W. Whitney School of Nursing
Catherine Ross, University of Wyoming Department of Communication Disorders
Lindsey Overstreet, University of Wyoming Department of Social Work

Introduction: Incivility is not always obvious. Sometimes it is subtle yet interferes with establishing a culture of trust, respect, and integrity—all necessary ingredients in today’s healthcare education environment. “Seemingly inconsequential ...words and deeds” promote negative emotions and create a hostile environment that interferes with quality care. Work place cultures that tolerate such behavior risk low morale, high turnover, and poor outcomes.

Innovation: The innovative, team building, Appreciative Inquiry (AI) method was adopted at one University Health System School of Nursing as both the philosophical and everyday strategy. All faculty,
staff, student and community stakeholders were included in the 4-step, AI process of discovering, dreaming, designing, and creating the school’s ideal future. Starting with a retreat during which facilitators from the School of Medicine role modeled appreciative communication and respectful dialogue, constituent participants asked each other positively worded questions that created the foundation of a strategic plan. The final plan included three goals, one of which focused on fostering well-being and collegial spirit. To achieve this goal, volunteers began engaging in appreciative activities to identify what a healthy work environment would look like. Thus, the Healthy Work Environment volunteers began the process of achieving the ideal.

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**Discussion:** AI is not well known in healthcare and education, yet is a powerful method to change dialogue and foster healthy work relationships and environment. One university health system is using this process to transform the culture

Relational Team Based Care: Improving Teamwork in Patient-centered Medical Homes

Authors:
- Shobha Pais, Indiana University
- Debra Litzelman, Indiana University
- Ann Cottingham, Indiana University
- Angela Rae Paxton, Indiana University
- Mary Jo Paladino, Indiana University

**Introduction:** As primary care practices work to become patient-centered medical homes, team goals, team member roles and team working relationships must transition as well. These new models of care necessitate increased team collaboration, shared decision-making, transparency in clinical practice, decreased autonomy, hierarchy and physician-centeredness. Strengthening relational culture and effectively facilitating the complex and challenging transitions from individual to team-based care are critical to success.

**Objective:** This project will implement and measure an innovative practice change strategy based on principles and techniques of family therapy, and designed specifically to cultivate core competencies essential for enabling effective team-based approaches to patient care. This strategy will serve as an important complement to existing QI, technological and physician-focused strategies. The intervention will build on the literature from family systems theory as well as relationship-development processes such as check in, self-reflection, relational conflict management and fostering of relational team dialogue. These techniques and abilities enable team members to attain a shared understanding of difficult team situations, improve reciprocal learning within the group, further clinician and staff competencies for relational coordination of work processes, develop and enhance team values, and reduce team member stress, all of which impact team functioning.

**Results:** Project still ongoing.

**Implications:** We anticipate developing an evidence-based model for health care teams with the relational abilities that enable them to interrelate with respect and trust, collaborate and coordinate work, solve conflicts, and communicate effectively, along with improved team performance.

Returning Values and Compassion to Healthcare in an Interprofessional World: An International Charter

Authors:
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- Suzanne Kurtz, PhD, College of Veterinary Medicine, University of Calgary, International Research Centre for Communication in Healthcare

**Introduction:** In today’s healthcare environment focused on efficiency models, clinicians and organizations must work to make the welfare of patients paramount by strengthening universal values in all healthcare relationships, organizational cultures, and learning environments. The International Charter for Human Values in Healthcare is an interprofessional collaboration to restore the primacy of human values necessary for practicing compassionate, ethical, and safe healthcare.

**Description of Innovation:** We established an international, interprofessional collaborative to identify and promote the human dimensions of care, beginning in 2010 and resulting in the Charter in 2011. An international working group of expert educators, clinicians, linguists, researchers, and healthcare leaders initially identified values that should be present in every healthcare interaction. This group and additional interprofessional groups - National Academies of Practice (NAP), International Conference on Communication in Healthcare, Interprofessional Patient-Centered Care Conference,
American Academy on Communication in Healthcare Forum - identified and prioritized values for all healthcare interactions. The NAP group also prioritized top values for interprofessional interactions. Additional data was gathered via Delphi methodology, and focus groups of Harvard Macy Institute scholars and faculty.

**Evaluation/Impact:** Through iterative content analyses and consensus, we identified five categories of core values that should be present in every healthcare interaction: Compassion, Respect for Persons, Commitment to Integrity and Ethical Practice, Commitment to Excellence, and Justice in Healthcare. Through Delphi methodology and further consensus, we classified values within each category. We are working to operationalize and implement these values in international healthcare settings.

**Discussion/Implications:** The International Charter for Human Values in Healthcare\(^1\) is an interprofessional effort to restore core values to healthcare around the world. Major healthcare and education partners have joined this international effort. We are developing methods to translate the Charter’s universal values into education, research and practice.

**Reference:**

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### Professionalism

#### Teaching Professionalism to Future Speech-Language Pathologists in Saudi Arabia

**Author:**
Areej Alasser, Dar Al-Hekma College

This session describes strategies for teaching professionalism in healthcare to students of speech-language pathology in Saudi Arabia. The approach involves discussion of case studies relevant to the Saudi culture and other Arab cultures that are widespread in Saudi Arabia (e.g., Yemeni, Egyptian, Jordanian, Lebanese, etc.). Students are required to analyze cultural and linguistic features of hypothetical clients in terms of dialectal variations, family dynamics, communication styles, gender relationships, and viewpoints towards healthcare. This understanding of cultural aspects better equips students to act professionally through their appreciation of appropriate versus inappropriate behaviors within different cultures. For example, students recognize that within a Saudi context it may be appropriate and expected of a female healthcare provider to shake hands with a female client, while the same behavior is inappropriate with a male client. Role-playing is also used to enact these case scenarios. Student performance is assessed in terms of the completeness of their analysis and the rationales provided for professional behavior with each client.

#### Professional Communications that Go Astray: Defining our Relationships, Why Things Go Wrong, and Prevention

**Authors:**
- Kathleen Franco, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University
- Richard Prayson, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University
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- Marcia Jarret, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University
- James Young, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University

**Introduction:** Fiduciary relations exist between patients and physicians and between medical students and their teachers. A fiduciary relationship occurs when one person places his or her trust and confidence in the more powerful party who has the duty to act in the other’s best interest. Greater knowledge, experience, and skills are offered by the professional. Students or patients should expect their best interests will drive communication and behavior. At times, the medical professional may exhibit behavior that stretches boundaries.

**Instructional Methods:** In order to introduce medical students to these possibilities, a session is held with incoming students regarding legal and ethical issues they may face. A senior faculty member introduces the topic, and students meet in small groups with a senior student or resident to go over case based scenarios.

Trainees discuss what is professional behavior, how to identify lapses, how to manage one’s responses to these circumstances and when and how to report. Outcomes of the various cases described on our poster are discussed in the summary by the facilitating trainee.

**Evaluation:** Participants repeatedly praised the sessions and vignettes. They feel empowered to manage and report difficult encounters. We have been able to alter behaviors and remove hurdles more expeditiously.

**Implications:** Teaching professional behavior and communication can be successfully accomplished in small groups led by senior trainees with supportive faculty available. Real behavioral vignettes allow discussion of the event, action, and outcome. The success of the teaching model for medical students has encouraged its adaptation in the residency program.
Attitude and Confidence in Communicating with Patients among Resident Physicians: A Pilot Study at a University Hospital in Japan

Authors: Hirono Ishikawa, The University of Tokyo
Takahiro Kuchi, The University of Tokyo
Masato Eto, The University of Tokyo
Kei Mukohara, National Hospital Organization Nagasaki Medical Center

Introduction: Numerous studies have confirmed the importance of communication skills for medical professionals. Although many medical schools teach communication skills for medical students, postgraduate education of communication skills is still undeveloped in Japan. This study aimed to develop a scale to measure physician's confidence in medical interview and explore its relationship with their attitude toward the patient-physician relationship and previous experience of communication skills training at medical school among resident physicians in Japan.

Methods: Participants were 63 first-year resident physicians at a university hospital in Tokyo. The physician confidence in medical interview scale was constructed based on the framework of the Calgary-Cambridge Guide. Residents were asked their confidence in achieving 21 specific behavioral objectives under the seven major tasks in the medical interview: 1) initiating the session, 2) gathering information, 3) sharing information, 4) planning, 5) closing the session, 6) providing structure, and 7) building relationship. In addition, the attitude toward the patient-physician relationship (Patient-Physician Orientation Scale; Krupat et al.), experience of previous communication skills training, and demographic characteristics were assessed through a self-reported questionnaire.

Results: The internal consistency of the scale was high (α = 0.92). As expected from the undergraduate curriculum of medical interview in Japanese medical schools, the scores in the areas of sharing information, planning, and providing structure were lower. The physician's confidence in medical interview was associated with more patient-centered attitude. On the other hand, no significant difference in the confidence and attitude was found by previous communication skills trainings, gender, and age.

Discussion: The scale may be a useful tool to measure physician's confidence in medical interview and to explore its change through the communication skills training. Further investigation is needed to confirm its validity and applicability.

Communicational Behaviour and Attitudes of 4th Year Medical Students

Authors: Andre Karger, Heinrich-Heine University Düsseldorf
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Ulrike Köhrner, Heinrich-Heine University Düsseldorf

Background: Research shows that medical students' attitudes towards doctor-patient communication grow after they had recognized its practical relevance in class. However, other surveys show a general decrease of patient-centered attitudes proportional to semesters completed in undergraduate education. Focusing on these inconsistent results we present an explorative survey of fourth year medical students' attitudes towards doctor-patient communication at the Medical Faculty of Heinrich-Heine-University Düsseldorf before and after they took part in a skill oriented small group communication training (CoMeD).

Method: In the beginning and in the end of summer semester 2012 students completed the Communication Attitude Scale (CSAS, Rees et al., 2002) which measures the positive and negative attitudes to healthcare communication.

During semester the students took part in 9 skill oriented communication training sessions (small groups, simulated patients encounters and feedback). At the end of the term the students passed a four station communication OSCE and were rated by experts with a global rating (Hodges et al., 2003) on four subscales (empathy, structure, verbal and non-verbal expression).

We hypothesized an increase of positive attitudes towards doctor-patient communication in general and a within a gender effect (i.e. higher attitude increase as well as better OSCE performance in female students. Furthermore we suggested a relationship between students' attitudes toward doctor-patient communication and their performance in OSCE.

Results: Surprisingly the results show a slight decrease of positive attitude towards doctor-patient communication nevertheless, these effects are not significant. No gender effect regarding OSCE performance could be revealed (F(1.56)=1.61 p=.16, partial Eta=0.003). However, male students consider doctor-patient communication as a central topic in class less important than female students. Results show significant effects of random sample in positive (F=6.34; p=0.013) and negative (F=4.51; p=0.036) attitude towards doctor-patient communication. Students who completed the survey show a more positive attitude to doctor-patient communication than students who discontinued the study. Furthermore results show negative correlations between students' attitudes toward doctor-patient communication and their performance in OSCE (r=-.27 (p<.05); r=-.01 (p=.49); r=-.25 (p=.09)).

Conclusion: Design and methods of the training courses as well as the high level stress of the OSCE (the time at which the second measurement was taken) could be an explanation for the attitude decrease.
Nevertheless the sampling effect could demonstrate that students who took part in the whole survey have an increased motivation to learn skills in doctor-patient communication. It seems that students’ attitude towards the assessment of communicational facilities is an important variable of influence. Results suggest as well that the more positive students confront the theme of doctor-patient communication, the better they perform in OSCE.

Assessing Professional Comprehension and Communication

Authors: 
- **Tram Nguyen**, McMaster University
- **Sue Baptiste**, McMaster University

**Introduction**: Integration of internationally educated health professionals into professional practice is essential for the prosperity and productivity in many countries globally. Comprehension and communication of professional terminology used within practice can be challenging and frustrating.

**Rationale**: Internationally educated occupational therapists (IEOTs) are a largely untapped resource for manpower recruitment; however, the potential for hiring IEOTs is under-utilized when they face language-testing requirements that do not reflect the actual language demands of the profession.

**Objective**: This presentation will: 1) inform the audience of a new evidence-based and self-reflective assessment for comprehension and communication of occupational therapy professional terminology, the MACC; and, 2) encourage professionals to consider the utility of this kind of approach in their own practice. The use of this approach and similar tools will facilitate inter-professional communication and collaboration within various practice settings.

**Results**: Preliminary findings of pilot testing indicate that this assessment can be used as a reflective process to identify areas of language difficulty and also to provide a catalyst between IEOTs, colleagues and employers. Those attending will gain understanding of the importance and complexity of professional lexicons facing foreign trained professionals when seeking to enter practice in Canada.

**Discussion/Implications**: Organizations need to be sensitive to, assess and address issues affecting speaking up behaviors by asking employees.


Barriers to Speaking Up for Patient Safety

Authors: 
- **Madeleine Ottosen**, University of Texas at Houston Medical School
- **Jason Etchegaray**, University of Texas at Houston
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- **Theresa Dansca**, University of Texas at Houston
- **Vanessa Beckman**, University of Texas at Houston
- **Eric Thomas**, University of Texas

**Introduction/objectives**: Momentum is building for healthcare providers to “speak up” when they perceive a patient safety issue, especially given links between speaking up and nurse turnover and serious patient safety events. Lucian Leape and colleagues recently issued a call to action focused on disrespectful cultures and their implications for patient safety. They argued these cultures likely reduce behaviors of speaking up in the workplace and create missed opportunities for organizational learning and improvement. The purpose of our study is to understand barriers that prevent healthcare providers from speaking up about patient safety concerns.

**Methods**: As part of an annual safety culture assessment for a large healthcare system in the Southern United States, we included an open-ended question asking providers “What barriers prevent you from speaking up about patient safety issues?” Responses were analyzed for thematic content by four independent reviewers with expertise in nursing, medicine and qualitative analysis.

**Results**: We received responses from 1,314 providers. Our preliminary results reveal strengths and opportunities for improvement related to speaking up. A strength is that 46% of the participants said they would “always speak up” or had no “reason to not speak up.” Areas for improvement involve recognizing participant fears to speaking up, such as the 17% who cited fear of retaliation, negative feedback, or punishment as barriers. An additional 13% of participants recommended improvements with management to listen to and take action when participants speak up. Finally, 4% participants noted barriers of time, either being too busy or not having the extra time.

**Discussion/Implications**: Organizations need to be sensitive to, assess and address issues affecting speaking up behaviors by asking employees.

Growing Together with Professionalism

Authors: 
- **Amritpal Pannu**, St Vincent’s Medical Center
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**Background**: Two of the ACGME Core Competencies for residency education 1)Interpersonal and Communication Skill(ICS) 2) Professionalism(P) have been shown to be essential to the delivery of high quality, safe patient care. Several groups have demonstrated that specific initiatives which target improving communication, professionalism, can have a direct and measurable impact on patient care.

**Goals**: To determine satisfaction related to ICS and P in the residency program. To facilitate development of a culture of professionalism, open communication, and respect for cultural diversity within the Program
Methods: Pre-test survey was used to assess the residents’ and faculty’s satisfaction on ICS and P. Questions focused on communication, professionalism, valuing diversity, program caring about resident’s work place satisfaction.

Intervention: Spotlighting biographic information of residents and faculty on their birthdays periodically to improve familiarity and understanding among program members, training workshops and seminars.

Post-test survey: To assess the resident’s and faculty’s satisfaction after the intervention on ICS and P.

Preliminary Results: Study involved 31 participants. Responses were analyzed by mean and standard deviation Overall all the areas obtained a positive response i.e. above zero, but some including program’s ability to provide constructive criticism and ability to deal with unprofessional behavior scored poor. The results show that the residents were satisfied with the program but barring areas especially the feedback (30%), appreciation for contributions (20%) and dealing with unprofessional behavior (25%).

Discussion: We propose that our project constitutes a sustainable way that the Program could foster the culture thereby improving patient care. While the effects of this project may not be immediate, but if cycle is repeated over time, quantifiable differences could be detected in the s interpersonal interactions, communication and professionalism within the program. Data can be further analyzed for an individualized approach to specific behavior changing interventions.

Language and Cultural Differences

Teaching Multicultural Competence of Physical Therapy Students Across the Nation

Author: Ann Lee Burch, A.T. Still University

Research indicates that health care providers have low self-efficacy, low levels of knowledge and attitudes of tolerance versus respect for providing health care to diverse patient populations. The Commission on Accreditation of Physical Therapy Education expects physical therapy educational programs to graduate students ready to demonstrate respect as providers to patients they serve. This study explores what schools of physical therapy throughout the US are teaching students with regards to multicultural competence and how learning is measured.

The first stage of this study was to survey faculty from a randomized list of 213 accredited physical therapy programs. 112 responses were collected. The survey used was validated based on feedback from a panel of six experts.

The second stage was a series of both on-site and skyped focus groups. Twenty out of eighty schools responded. Nine schools confirmed arrangements for onsite meetings or skyped meetings. Survey data was analyzed using descriptive statistics and responses were categorized using transtheoretical theory and the stages of change model for diversity self-efficacy. Focus group analysis included thematic clustering of common themes during the 1.5 hour sessions.

Quantitative analysis showed four survey question groupings. Correlations between questions were measured by Cronbach’s alpha with some relationships showing values between .75 and .86.

From the qualitative analysis nine themes across the focus groups emerged. The nine themes were 1) self-assessment as a first step; 2) dynamic nature of defining cultural competence; 3) importance of experiential learning; 4) faculty are not visibly diverse; 4) religion is hard to talk about; 5) sexual orientation is hard to talk about; 6) cultural blindness doesn’t work; 7) not always about what we teach but how we teach it; 8) one faculty member champions cultural competence; 9) international experiences are well intentioned but vaguely defined.

With Gestures, Like Deaf-mute, Once Understands Each Other, Isn’t it? The Use of Cultural-linguistic Mediation Facilities in the Tuscan ASL: System Fragility and Failed Opportunities

Authors: Giulia Capitani, Scuola S.Anna
Sara Barsanti, Scuola S.Anna
Sabina Nuti, Scuola S.Anna
Gavino Maciocco, Scuola S.Anna

Introduction: The project “Migrants and Health. Key route to social integration” aimed at mapping the ways of access to regional health services by migrant users and proposing effective solutions for reducing inequalities and promoting an appropriate use of services in Tuscany Region, were foreign citizens are 9% of 3.6 millions of inhabitants.

Methods: The research activities were carried out with Qualitative approach, conducted by 16 focus groups with health operators and administrative staff (about 100 operators) and 12 focus groups with foreign users (about 100 migrants), and also interviews with 24 non Italian-speaking migrants.

Results: Several users ignore the existence of the mediation facilities, that are barely insufficiently publicized. Others complain the difficulties to activate them or that they are never sure to be allowed to benefit from it. For this reason foreign users tend to use improper mediation services as Italian speaking compatriots. Operators give various explanations as lack of training of the facility and its way of activation, scarcity of mediators or not timely service. The paradox is that operators affirm the mediation services are often unnecessary since they feel able to express themselves and to be understood by migrants using gestures or speaking slowly.

Discussion: The underuse of facilities depends on the lack of training opportunities illustrating their features and potentialities to operators. Such occasions should also make operators aware of the serious risks connected to incomprehension as well as of the opportunity to have qualified mediators. On the other side it would be necessary to help users to be able to activate the facility, in order to avoid the vicious circle of an inappropriate mediation. A systemic training for operators, a rethinking of the ways and procedures to arrange facilities and their promotion outside emerge all as real needs.
Working with Medical Interpreters in Pediatric Hematology/Oncology (PHO): Shared Difficulties by Interpreters and Fellows

Authors: Wilson File, UT Southwestern Medical Center
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Patrick Leavey, UT Southwestern Medical Center

Background: Language barriers in medicine are associated with family dissatisfaction in quality care and an increase in provider time necessary to care for patients. In 2010, 9% of the US population had limited English proficiency (LEP). Only 23% of teaching hospitals in the US provide physician training working with medical interpreters.

Objectives: To evaluate training in working with medical interpreters among PHO fellows and to explore shared challenges experienced by both PHO fellows and interpreters related to language barriers.

Methods: An online survey was distributed to 315 PHO fellows via the American Society of Pediatric Hematology/Oncology fellow registry. A separate survey was distributed to 50 Spanish medical interpreters at Children’s Medical Center Dallas. Each group received an initial request to participate and 2 reminders, while fellow participation was encouraged through a random incentive drawing. Both groups were asked questions exploring factors that enhance and difficulties with accurate interpretation.

Results: One hundred ten fellows responded (35%), of whom 60% had never received any training working with medical interpreters. Respondents reported the most common difficulties in medical interpretation were: increased provider time and inability to address cultural issues. Fellows reported factors enhancing clinical encounters were: accurate interpretation of provider words, mimicking provider’s emotional tone and provider sentence length. Twenty-nine Spanish language interpreters responded (58%). Interpreters reported factors associated with success of clinical encounter were: length of provider sentences, speed of provider communication and provider led pre-session to orient interpreter. Interpreters reported the most difficult elements to convey during patient encounters were: medical terminology and family emotional tone.

Conclusions: PHO fellows have little training in utilization of medical interpreters. There is a need for a curriculum addressing working with interpreter services and emphasizing: provider communication speed and sentence length, importance of conducting a pre-/post-session with medical interpreter and techniques to explore cultural issues.

The Health for All Network: An Institutional Response to a Multicultural Urban Population

Authors: Melissa Dominicé Dao, Hôpitaux Universitaires de Genève
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The Geneva University Hospitals (HUG) serve an urban multicultural population of 600’000 in Switzerland. Over half of patients as well as hospital personnel are foreigners. About 40% of patients speak another language than French as their first language. This diversity poses a number of challenges for the institution, which include language barriers, cultural misunderstandings, complexities regarding administrative and insurance issues, or lack of knowledge of external resources available for migrants and vulnerable populations. To answer the needs of their diverse patient population, the HUG have developed since the 1990’s a number of specific hospital structures (interpreter services, consultation for undocumented migrants or for asylum seekers, etc.). Despite the specialized expertise developed, these structures remain insufficiently known or used by the mainstream health care professional at the HUG. Funded by “Migration and Health” strategy of the Swiss Federal Office for Public Health since 2010, the “Health for all” network was created to increase collaboration between these structures, to promote their visibility and use within the institution and to develop further projects to guarantee a high quality of care for all patients including migrant patients. Four main axes were identified: a) early identification of patients with specific barriers to care (language, lack of insurance …), b) reduction of the language barrier, c) promotion of existing institutional resources, d) training in cultural competence for health care staff. This poster will present results from the initial evaluation that led to the development of these four axes, as well as specific actions taken within each axis to enhance the health care of migrant patients at the HUG.

Breaking Down Linguistic Barriers for Access to Health Care for Deaf Persons in the English Speaking Community of Quebec

Authors: James MacDougall, McGill University
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This project is focussed on intercultural communication and language barriers faced by the minority Anglophone Deaf community in Montreal, Quebec. It is well known that Deaf people who use sign language (ASL) as their primary means of communication and who identify with Deaf Culture experience difficulties accessing virtually all aspects of healthcare. In 1997 the Supreme Court of Canada mandated free sign language interpretation for all services covered under the Canada Health Act. While this landmark court decision led to a significant increase in the availability of interpretation services, minority populations, such as the Anglophone Deaf in Quebec, continued to face serious challenges in accessing basic healthcare.
To address the issue of health access for Anglophone Deaf people, a project was developed involving an information package and an online (iBook) Tool-Kit. The Tool Kit was involved in direct consultation with the Anglophone Deaf community and, as well, an online (Survey Monkey) questionnaire regarding knowledge of deaf health access issues was given to a sample of professionals in health settings in Montreal. The questionnaire assessed the desire on the part of health professionals to obtain more information on topics ranging from: general information on deafness, use of sign language interpreters, use of communications technology and issues related to confidentiality and privacy when using interpreters.

Based on the responses from health professionals and in consultation with the Deaf community, an interactive Tool-Kit was developed which addresses all the issues that were highlighted during the project. The use of innovative communications technology such as the iPad and other tablets in addressing the interpreter shortage was highlighted. The kit is available in print as well as electronically, and includes brief videos which demonstrate the frustrations that Deaf people experience in the health system when communication breaks down.

Medical Interpreting: Crossing Languages in Diverse Institutional Contexts

Authors: Michael Nathan, Harvard Medical School
Seth Hannah, Harvard University
Elizabeth Wahl, Harvard Medical School

Objective: Extend understanding of the interpreters' role in medical encounters.

Methodology: Qualitative interviews of medical interpreters and other staff in multiple medical settings.

Summary: As the population of those with limited English proficiency increases, the medical interpreter is becoming more and more vital to quality patient care. However, the role of the interpreter often varies across and within different clinics and hospitals, and while consensus standards governing training are evolving, the ground practice remains highly variable. The expectations for quality interpreting are influenced by the local needs of particular clinical environments, larger movements to strengthen the professional status of medical interpreters, and advocacy movements for patient-centered care that recognize the importance of cultural and linguistic differences in the medical encounter. Healthcare providers and institutions enable and frustrate the knowledge and practices of individual interpreters. Conflicts arise over theory and methodology, different views are asserted regarding the incorporation of extra-biomedical factors such as the life history, social context, labor conditions, or family responsibilities of individual patients. Drawing on in-depth interviews with medical interpreters, refugee care specialists, and managers in three clinics, we analyze the factors driving these divergences. We focus on the exigencies of practice (race, ethnicity, immigration status of patients and providers), as well as the political economy of care and institutional and system-level practices that structure and maintain specific forms of practice (including formal and informal rules, systems of accountability, and status differences between professions).

Challenges in Multicultural Physical Therapy Practices through the Eyes of the Professional: A Qualitative Study

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Introduction: The research question underlying this study was: Which problems do physical therapists experience during screening, diagnoses and treatment of immigrant patients in deprived areas of Utrecht, The Netherlands?

Methods: A qualitative descriptive study using semi-structured interviews and focus group interviews. Twelve experienced physical therapists working with immigrant patients participated as respondents.

Results: Seven main problems were found. Listed from most mentioned to least mentioned the main problems were: 1. ‘language barriers’, 2. ‘Logistical problems’, 3. ‘Differences in clinical reality’, 4. ‘Poor understanding, knowledge and skills of patients’, 5. ‘Differences in values, standards and manners’, 6. ‘Contextual factors that keep the patient from recovering’ and 7. ‘Negative feelings/emotions of the therapist’. Within one treatment cycle multiple problems can occur and influence each other. This can lead to highly complex treatment situations. Therapists reported that these seven main problems are not exclusive to treatment of immigrant patients, but are mainly associated with treatment of patients with low health literacy skills. There is, however, a difference between the treatment of immigrant and native patients with low health literacy skills. Therapists attribute these differences to immigrant status and cultural background. These two factors make it harder for them to find suitable solutions for the problems experienced.

Discussion: Seven main problems were experienced by therapists during treatment of immigrant patients. These problems seem to have a stronger relation with low health literacy skills of patients than with immigrant background. Cultural background and immigrant status are not likely the key factor in the occurrence of these problems. However they seem to complicate the treatment situation.
Measuring Discordant-Language Health-Communication Anxiety: The DLHC-Scale

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Introduction: Language barriers in health settings can arise when health providers and patients have different first (L1) languages (language discordance). Communicating across language barriers can impact patient-provider relationships and affect information exchange. In particular, patients may be anxious about using a second language (L2) to discuss health and thereby less willing or able to ask/answer questions, describe themselves, and interpret health-relevant information in the L2. However, beyond L2 health-communication anxiety, people also vary in willingness to talk about health in the L1 generally. It is important, therefore, when assessing L2 health communication anxiety to control for these factors. Such controls are lacking in current L2 health-communication research.

Objective: To create a Discordant-Language Health-Communication Scale (DLHC-Scale), with appropriate controls, for assessing health-communication anxiety in language discordant situations.

Method: Building on existing health-communication and related L2 literatures, the DLHC-Scale includes L1 and L2 subsections, each employing 21 seven-point Likert-type scales. Frequency of health services utilization in each language was assessed separately. We used Cronbach-α, Principal Axis Factoring analysis, and follow-up regression analysis to assess reliability and validity of the DLHC-Scale. Participants were Montréal L1-English/L2-French university students who regularly use L2 French.

Results: Factor analysis revealed two factors underlying the L1 and L2 subsections—with a similar anxiety factor in each accounting for 36.2% and 46.9% (α’s > .93) of the variance respectively, and a communication behavior factor accounting for 9.7% and 6.6% of the variance respectively (α’s > .71). Regression analysis revealed that L2 health-communication anxiety significantly predicted frequency of use of L2 health services, even after controlling for L1 health communication anxiety and frequency of L1 health services utilization (ΔR²=.187, p=.001, β=.457, p=.001).

Discussion: The DLHC-Scale is a valid measure of L2-specific health-communication anxiety. This has implications for research on healthcare access for linguistic minorities.

Minority Health and Healthcare Disparities

Socioeconomic Inequality in Life Expectancy of Anglophones in Montréal

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Introduction: Anglophone and Francophone life expectancy has converged over time in Montréal, but the contribution of socioeconomic status to linguistic differences in life expectancy is not understood. We sought to determine how life expectancy of Anglophones in the metropolitan area of Montréal varied by socioeconomic status, and how these trends compared with Francophones over time.

Methods: We calculated life expectancy at birth for Quebecers reporting English or French language spoken at home for two periods, 1989-1993 and 2002-2006. We used a local area measure of socioeconomic status, based on a composite score of census socioeconomic data, to identify wealthy and poor residential areas of decedents. Time trends in life expectancy of wealthy and poor Anglophones and Francophones was examined. We partitioned the causes of death that contributed to the difference in life expectancy between wealthy and poor Anglophones in 2002-2006.

Results: Life expectancy at birth increased over time for wealthy and poor Anglophone men and women in Montréal. Life expectancy in 2002-2006 was greater for wealthy and poor Anglophone men than Francophone men. However, life expectancy of wealthy Francophone women increased much faster than wealthy Anglophone women, such that inequalities reversed in this group by 2002-2006. The life expectancy gap between wealthy and poor Anglophones in 2002-2006 (men 5.0 years, women 1.6 years) was mainly caused by differences in cardiovascular and cancer mortality rates.

Discussion: Life expectancy of wealthy Francophone women has surpassed wealthy Anglophone women, but this reversal did not occur for men or poor Anglophones. Cardiovascular disease and cancer were responsible for a large part of the socioeconomic gap in Anglophones. These results imply that language status may be an important factor in the measurement of life expectancy in Québec, and that Anglophone women in Montréal may be an emerging vulnerable minority language group.
Care Pathways of Non-western Immigrant Cancer Patients in Belgium. Having Cancer in a Foreign Country

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Introduction: The rising number of immigrants in Western Europe has implications in many areas, including healthcare. This subpopulation has difficulties in finding their way into the complexity of the health care system, especially when being diagnosed with a life threatening illness such as cancer. Although, there is an urgent need for insight and knowledge about these patients, most research excludes this population, because of the various difficulties it entails.

This study intended to map the care pathways that non-western immigrant patients follow when diagnosed with cancer, as well as to study their expectations and experiences about the provided care in Belgium.

Methods: Thirty adult non-western immigrant cancer patients were interviewed by means of an in-depth interview technique. The interviews were coded using thematic analysis.

Results: Having a life threatening illness is in essence a human experience, regardless of one’s country of origin. Patients showed universal reactions and reaction patterns when confronted with cancer and dealing with the cancer treatment. Nevertheless, there were some obstacles. The language barrier between immigrant patients and healthcare workers seems the most important obstacle in the care for these patients. Moreover, more than half of the interviewed patients preferred independent interpreters instead of family members for translation during consultations. Finally, we noticed throughout the interviews a general lack of basic knowledge about health and illness, resulting in an enormous need for (medical) information.

Discussion: In general, we found strong resemblances in the expectations and perceived experiences between immigrant and native patients when confronted with cancer. However, in many interviews we saw important obstacles while dealing with the illness, such as a language barrier and a need for information. Thus, besides overcoming the language barrier by using independent interpreters, instructing this subpopulation about health and illness is needed.

Double Jeopardy: Latino Women, Information, Health and the Gender Divide

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Introduction/objectives: Latinos comprise the largest minority group in the United States, representing nearly 15 percent of the nation’s 300 million people, and they are the nation’s fastest growing minority group. The present study explores how gender influences perceived quality of health and health-information use disparities among Latinos and in comparison with the white majority. Research on factors affecting Latino women’s health is limited, even though a significant number of studies have examined ethnic-driven health disparities by comparing Latino and non-Latino populations.

Methods: The source was national data from the 2010 Health Tracking Survey; after identifying the specific variables accounting for information encounter and usage, health care access, perceived quality of health, and demographics, researchers used descriptive and nonparametric statistics on to quantify observed differences between groups.

Results: The sample consisted of 60.7 percent women and 39.3 percent men. There were no statistic significant differences in gender distribution between the Latino and white samples. Our research found that gender and ethnicity do combine to affect income, health status, and quality of life. Being Latino and female may translate into limited access to health care and poorer perceived health than being Latino and male, or compared to the white population.

Discussion/Implications: Because Latinas have lower income, limited access to health insurance and, possibly, health information on the Internet, public health professionals need to consider alternative strategies to reach this particular group of women with disease prevention and health promotion messages as well as information about available medical services. Further research on how Latinas obtain information and whether they feel empowered to act on that information is needed.

The Impact of Implicit Bias on Quality of Communication in Health Care Encounters

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Thousands of studies have demonstrated that under-represented minority adults and children are less likely to get appropriate, guideline-concordant, and cutting-edge medical care than their White counterparts. A variety of other clinically irrelevant social identify factors such as sexual orientation and education have also been shown to affect provider behavior, medical encounters and patient satisfaction and health outcomes. Despite this, there has been very little progress towards eradicating inequities in care. A decade ago we proposed a conceptual model illustrating a set of hypothesized mechanisms through which providers’ cognition, decision-making and verbal and non-verbal communication during health care encounters might contribute to inequalities in care. Empirical evidence has supported many of these hypothesized mechanisms, demonstrating that medical care providers sometimes: 1) hold negative implicit (unconscious) biases and explicit stereotypes; 2) have implicit racial and other biases that persist independently of and in contrast to their explicit (conscious) attitudes, 3) are influenced by implicit bias in their verbal and non-verbal behavior as well as their decision-making. This, in turn has been shown to affect the quality of communication as well as patient trust and satisfaction with clinicians. This presentation describes an updated model of the provider contribution to disparities in care with a special focus on the impact on health care communication. The model incorporates new evidence from several disciplines regarding the individual, situational and context factors that influence the likelihood that implicit biases will affect provider behavior, patient behavior, or both. Empirical evidence will be used to illustrate the way a complex interaction between setting factors, provider unintended biases and patients’
experiences of discrimination and/or stereotype threat can independently and in combination influence communication during health care encounters. The talk will conclude by applying the latest evidence regarding modifiable factors to specific recommendations for preventing inequities in interpersonal quality of care.

Patient-centeredness

Factors that Influence Doctor-Patient Communication Skills: Focusing on the Hidden Curricula

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Introduction/Objectives: Effective doctor-patient communication has been shown to affect multiple outcomes including patient satisfaction1-4 and adherence to medication.5,6 Studies suggest that communication skills are influenced by personal factors (such as age and gender)7 but also by training.8 Several Medical Schools include communication skills training as part of their official curricula.9-11 However, qualitative studies with medical students and residents suggest that informal and hidden curricula can influence students’ patient-centered attitudes and behaviors in clinical practice.12-16 The aim of this study is to review the literature about factors that influence learning and maintenance of patient-centered communication skills, focusing on informal and hidden curricula and, specifically, on the importance of role modeling.

Methods: A search on Pubmed Medline from inception until June 2013 uses combinations of the terms “doctor patient relation”; “patient centeredness”; “training”; “learning”; “informal curricula”; “hidden curricula”; and “role modeling”. Qualitative and quantitative studies addressing any type of factor that can influence doctor-patient communication learning and maintenance are included. Found factors are organized by categories (type of training, personal factors, clinical practice factors and institutional factors) and reviewed in terms of amount of evidence.

Results: Studies suggest that type of training (e.g., theoretical/practical; occasional/longitudinal), personal factors (age, gender, coping styles), clinical practice factors (length of practice, time since medical school) and institutional factors (tutors’ and peers’ attitudes, pressing for outcomes) can influence doctor-patient communication and interfere with learned contents in this field. Our ongoing study indicates that the amount of evidence for each of these factors varies widely and is higher for aspects such as type of training.

Discussion/implications: Effective training on doctor-patient communication skills involves teaching contents and training practical skills, but must also address factors that influence the use of these skills in daily practice. Understanding the effect of institutional and role models’ characteristics can help to promote and sustain a patient-centered approach in medical practice.

Reciprocity and Impact of Nonverbal Behavior in Patient-Centered and Clinician-Centered Interactions

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The purpose of this research was to identify the coordination and presence of nonverbal behaviors and the impact of these behaviors on impressions of the interaction in physician-patient interactions. Participants (N = 8, 100% female) were a subset of patients recruited for an fMRI study of patient-centered interviewing. The same physician conducted either a patient centered interview (PCI) following a 5 step behaviorally defined method, or a clinician centered interview (CCI) that was a standard interview with focus on diagnosis and exclusion of emotional and personal information. Smiling, nodding, and self-touch of the physician and patient were coded in 30-s intervals. Correlating the frequency of each physician behavior with the respective frequency of patient behavior across the 30-s intervals assessed coordination between the physician and patient. Observers made impression ratings of the physician’s and patient’s warmth, dominance, anxiety, and attentiveness as well as the rapport of the dyad. Patient satisfaction was related to more doctor nodding (r=.88) and smiling (r=.83), and more patient nodding (r=.74) and smiling (r=.66). Independent t-tests showed significant differences in self-touch coordination between physician and patients such that in the PCI, physicians and patients had significantly more coordinated self-touch behavior than in the CCI, t(5)=3.08, p<.05. Across interactions, more self-touch coordination predicted patient satisfaction (r=.78). Reciprocity between patient and physician was evident in significant correlations between patient and physician on warmth (r=.88), anxiety (r=.78), and attentiveness (r=.78) while dominance was negatively related between patient and physician (r=.36). Results corroborate past research illustrating the importance of physician nonverbal behavior on patient satisfaction. The current research also adds to the existing literature by showing the importance of reciprocity and coordination of the nonverbal behaviors of patients and physicians particularly in PCI.

Influence of Patient-Centered Communication (PCC) on Perceptions of Illness, Self-efficacy for Coping Behaviors and Psychological Distress in Breast Cancer Women

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Purpose of the study: Patient-Centered Communication (PCC) consists of providing care that goes hand in hand with the patients’ values, needs and preferences, and that permits patients to give input and participate actively in decisions making concerning their health (Epstein et al., 2005). Many positive outcomes are associated
with some aspects of PCC on the well-being of women with breast cancer namely improved emotional health, optimal self-management over the disease and increased control over the illness (Davies et al., 2008; Fallowfield et al., 1994; Hack et al. 2006; Lerman et al., 1993; Morris & Ingham, 1998). Illness perceptions are often used to explain how individuals manage their disease (Leventhal et al., 1980). However, no study has examined the impact of a PCC between breast cancer patients and healthcare providers on how women perceive their disease and illness and the effect on symptom self-management. This study will examine the role of PCC on perceptions of illness, self-efficacy for coping and psychological distress.

Methodology: Women with early breast cancer will be recruited during outpatient medical appointments with their oncologist at a Toronto Hospital, during their 2nd cycle of chemotherapy. The Patient Perception of Patient-Centeredness questionnaire will be supplemented to the other self-administered questionnaires (Brief IPQ-R, CBI-B, HADS). Semi-structured interviews will also take.

Statistical analyses: Multiple regressions will assess how much variance in illness perceptions, self-efficacy for coping and psychological distress is explained by PCC. Patients and disease-related factors will be controlled as confounding variables. Mediation analyses will verify if the association between PCC and the outcomes is mediated by the illness perceptions. Qualitative data will be analyzed using Patton’s (2002) content analysis procedures.

Clinical implications: Interventions could be put in place to improve the communication skills of both healthcare providers and breast cancer patients if PCC helps the women manage their illness.

Teaching and Evaluation

Examining Patient Communication Behaviors in the Medical Interview: Towards Creating Enhanced Patient Medical Communication Skills Training

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Effective physician-patient communication requires both parties to be actively involved in the medical encounter and engage in competent, skills-based communication. When both parties are actively involved in the medical interview, they achieve a patient-centered encounter resulting in both improved physician and patient satisfaction and better health outcomes. Most medical training programs address physicians’ communication skills, but few studies have asked the physicians’ perspective of their patients’ communication behaviors in medical interviews. The purpose of this research project is to investigate physician-patient communication from the perspective of physicians’ across medical specialties. The data collected from this study explores themes and responses from a survey of randomly sampled licensed and practicing physicians in the State of Florida inquiring about patient communication behaviors during the medical interview. Preliminary results indicate the top five patient behavior issues cited by physicians as being the most difficult behaviors during the medical interview include: (1) patient does not actively listen to the whole message discussed by the physician (82%), (2) patient tells a physician they understand a direction when they actually do not understand (72%), (3) patient does not make their agenda for the medical interview clear to the physician (67%), (4) patient does not provide detailed medical or sensitive information for the physician (75%), and (5) patient does not ask physician questions or state concerns when they do not understand or comprehend (72%). Interestingly, using the Mann-Whitney-Wilcoxon test, significant physician gender differences were seen on four of the five patient behavior issues (p<.05). In our presentation we will present more complete results from our survey. We will further discuss communication training opportunities designed to enhance patient education targeted for medical encounters and to further enhance the physician-patient relationship.

Integration of Communication Skills in High-fidelity Simulation

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Background: Teaching communication skills in the clinical setting is challenging. High-fidelity simulation provides an environment that reproduce real clinical settings. Technical and diagnostic skills are usually addressed during this type of simulation. Furthermore, by using actors playing the role of patients or patients’ family and real healthcare professionals playing their own roles, high-fidelity simulation provides an interesting setting to tackle communication issues.

Summary of work: A high-fidelity simulation was developed to reproduce situations encountered during on-call shifts of first year internal medicine residents. The On-Call Simulation Exercise (OCSE) was held at the Simulation Center of the University of Montreal. The OCSE consisted of three simulated scenarios throughout a 90-minute session. With regards to communication skills, scenarios were created with emphasis on communication between residents and their own colleagues, patients’ family and other healthcare professionals.

Summary of results: The debriefing sessions following the simulated scenarios were structured to discuss specific issues related to communication skills. The discussion was an opportunity to reflect and share thoughts on various communications problems encountered in the clinical setting and more specifically, during on-call shifts.

Discussion: High-fidelity simulation provides opportunities to teach communication skills in realistic and safe clinical settings.
The CURE for Annie: An Innovative Women’s Health Curriculum for Family Medicine Residents

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Introduction with institutional context and educational objectives: Recurring “didactic” teaching sessions for family medicine (FM) residents are often fragmented lectures utilizing sub-specialists, an approach dissonant with FM’s emphases on integrative/longitudinal care. In an effort to positively impact residency education, the Medical College of Wisconsin’s Department of Family and Community Medicine created CURE (Coordinated Units in Residency Education). A theme based longitudinal lecture series. The 2012-13 Women’s Health series emphasizing continuity and integration of psychosocial and community care elements, delivered by experienced FM faculty. This evaluation highlights residents’ reactions, learning and care planning. Seven teaching sessions occur Sept 2012 through May 2013. At the first session residents create a virtual patient “Annie” as a pre-teen, and she matures (by May) to old age. Annie keeps a monthly journal that reveals issues expected to influence care (e.g., substance abuse, domestic violence). Each month her case is discussed in small groups (n=6-8) aligned with the day’s didactic sessions.

Methods: Evaluation includes end-of-session numerical scores/comments, and group worksheet results. Worksheets elicit resident plans based on Annie’s journal: How to manage the office-visit, and recommended use of clinic and community resources. Analysis uses descriptive statistics and content analysis/category development.

Results: Attendance (N=58) ranged from 19 (33%) - 32 (55%), and satisfaction (1=poor, 7=excellent) from 5.6 to 6.7. At first, residents were confused about Annie being a long-term patient. However, Annie’s journaling stimulated consistent group discussion on care strategies. Monthly worksheet average: 46 entries in four categories: elicit detailed information (46%), referral to community (26%) or clinic resources (15%), and provide counseling (13%).

Discussion: Utilization of a virtual “Annie” is innovative and prompts residents’ discussion of wide-ranging care strategies. In addition, this approach targets patient-based learning. Low resident attendance justifies attention to course management and work hour restrictions.

After-hours Telephone Medicine: Often Used, Rarely Taught

Author: Laura Freilich, Michigan State University

Introduction: Physicians spend up to 25% of their time on the telephone, but few residency programs offer training in telephone medicine. While it differs from face-to-face care, telephone medicine can be taught. Because the ACGME, IOM and Healthy People 2020 recommend after-hours accessibility, we introduced a telephone curriculum in a medicine residency with the objective to improve residents’ confidence in approaching telephone encounters.

Instructional/Assessment Methods: We implemented one unit of a larger curriculum, The Basic Telephone Encounter, as a pilot program for eleven senior residents in March 2011. The 1-hour unit comprised a 15-minute didactic session, a 15-minute pre-recorded demonstration, and 30 minutes of role-play using three scenarios. Training highlights organizing the encounter and communication skills. One month later, we audio-recorded one encounter with a simulated patient (SP) of each resident during a call night. IRB approved, residents were not told which encounter would be recorded. SPs were clinic patients with an active EMR record. They received a brief introduction to the project and a 15-minute practice session with the author. After first receiving 30 minutes of instruction on the checklist, two faculty evaluated the interactions based on a 24-item checklist adapted from Reisman and Curtis. Additional evaluation included resident-completed questionnaires about the training and a retrospective pre/posttest self-efficacy questionnaire.

Results: Eleven residents reported improved understanding of telephone medicine and ten residents reported improved confidence. Most did well in the disease-based portions of the encounters but struggled in eliciting and handling emotions.

Discussion/Implications: Medicine needs formal education in the common practice of using a telephone. We report a curriculum well received by resident learners that improved confidence in and understanding of telephone medicine. We identified a need for improvement in addressing personal issues in future training.

Faculty Training in Behavioral Health

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Introduction: Medicine largely ignores mental health care by not providing training to the primary care doctors who see most of the patients. This 5-year HRSA grant produced a curriculum for primary care faculty and, subsequently, their residents to learn behavioral health issues. In the past 12 months, three faculty members completed training modules in psychosocial medicine and mental health care, and are now working in a special medical clinic for diagnosing and treating mental health problems. This presentation provides a longitudinal description of the responses of the faculty to learning behavioral medicine.

Methods: Focus groups of 1-2 hours for three primary care faculty conducted at 6-month intervals assessed and documented reactions to the training. Two focus groups have been completed; two more are scheduled for July and October.

Results: Focus Group 1: psychosocial medicine training. Physicians appreciated the opportunity to be part of the training project. Training helped them better manage time with patients, provided a better understanding of personality types, and provided new tools...
to effectively manage interviews with difficult patients. Key recommendations: 1) increase skills training; 2) reduce seminars - connect theory to observed outcomes during skills training; 3) ensure time is protected for necessary preparation outside the training itself.

Focus Group 2: psychiatric training. Physicians continue to provide positive feedback. Key recommendations include: 1) content focus should be more in areas most likely to benefit primary care; 2) more time is needed observing the psychiatric faculty and talking with psychiatric patients.

Focus Group 3: complex patient management. The July and October focus groups will assess reactions to applying the skills in practice.

Discussion/Implications: Primary care faculty liked and reacted well to experiential training, essential information if we are to teach and conduct now lacking mental health care.

An Online Self-assessment Tool for Nurses Learning ESL in Québec

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One of the most demanding situations for members of linguistic minorities is a conversation between a health professional and a patient. This can consequently compromise the quality of healthcare that is provided. This project aims at developing a self-assessment tool on-line to support nurses’ language training in the development of their ability to provide services in their second language to English-speaking minorities in Quebec.

An earlier study provided an empirical basis for deciding the content. Combining focus groups with experts and the use of questionnaires (N=133), relevant tasks in the nurse VS patient oral interactions were identified. Among these, 11 are included in the assessment tool because of their complexity and relevance in professional situations. For example, Describing common interventions to patient is considered a professional task that carries a language component that may create a communication gap.

Five brief scenarios were created to represent typical and engaging clinical nurse-patient interactions, and to naturally elicit the tasks. The learners may have to answer a multiple choice question, choosing the most appropriate nurse response to the scenario (in both grammatical and pragmatic terms) or record their own oral response and compare it to a variety of pre-recorded acceptable responses.

Senior nursing students (N=14) were presented with each scenario and asked to evaluate its authenticity, and to respond to each part of the scenario with what they would typically say in that situation. The nurse responses provided us information on the authenticity of the scenarios and examples of typical nurse responses.

The self-assessment tool is available on the Web, free of charge, and the learners’ response will be collected. This data will allow us to analyze the functioning of the activities in order to improve the prototype.

Novice to Expert Communication Skills Using the Electronic Health Record during History Taking

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Introduction: This study investigated student nurse practitioners’ (novice) communication skills when utilizing the electronic health record (EHR) during practice history taking. Unfortunately, introduction of the EHR to providers seems to have focused primarily on the documentation and billing aspects. Therefore, identifying “novice to expert” EHR communication skills is essential.

Objective: Participants will examine common student challenges in communicating when the EHR is utilized during history taking.

Methods: Nurse practitioner students (n=36), recently instructed on EHR use, were videotaped during two visits with standardized patients (formative and evaluative). Using OD LOG software, two observers recorded student time spent: typing and talking, typing only, and looking at computer without talking. Total time of history taking and placement of the computer was recorded. Inter-rater reliability was 0.84. Findings: On the formative visit- mean history taking time was 11.4 minutes. Of this time, a total of 3.5 minutes were spent: typing and talking (45.9 sec) typing only (125.1 sec) and looking at computer not talking (37.3 sec) for 30.6% of this visit. One the evaluative visit- mean history taking time was 12.4 minutes - of this time, a total of 2.95 minutes were spent: typing and talking (31.9 sec), typing only (124.7 sec) and looking at computer not talking (20.9 sec) for 24% of this visit. A slight difference was noted between mean group times ( p = 0.361). The percent of time spent by individuals changed over the two visits: Typing and talking (-3.1%, p= 0.3); typing only (+12.8%, p=0.038); looking at computer (-9.6% p= 0.039). Survey of experience providers and literature review will provide the “expert” comparison.

Discussion/implications: Students need instruction on introducing EHR documentation into the patient visit and practice navigating the EHR while history taking. “Best Practices” for communication skills when using the EHR must be developed and tested.
Drug and Alcohol Addiction in the Medical Community: Prevention Using the Communication and Clinical Skills Education Simulation Activity

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Background: Drug and alcohol addiction are important problems in the medical community,1,2,3 and often begin during pre-graduate studies. We present a simulation training activity to raise awareness of addiction for our 300 second-year clerkship students using an interactive approach including unexpected personal accounts of addiction experience. This powerful communication tool sensitizes students to these problems and seeks to effect behaviour change and/or prevention.

Work: We have held a 90-minute workshop for the past 3 years that includes an apparently typical simulation activity on behaviour, with preliminary home-based study on this problem and two role-playing scenarios followed by debriefing in small groups. However, the activity concludes with candid and surprising testimony from the presenter on their personal experiences with addiction. An animated discussion follows.

We take advantage of this activity to distribute brochures to the students from the Student and Resident Aid Office.4 Similar resources exist for practicing physicians from the PAMQ (Programme d’aide aux médecins du Québec).

Results: Fourth year medical students strongly appreciated the activity year after year, and responded positively as described in a survey (included in the poster).

Conclusion: This workshop was sufficiently well-received that the faculty of medicine has now extended it to all undergraduates as part of the regular curriculum.

We believe that this interactive workshop is a powerful tool to sensitize students to addiction problems in the medical community and to introduce appropriate procedural approaches to address them.

References:
4 Video: Wearing Masks http://mediamill.cla.umn.edu/mediamill/embed/26986
5 Video: Wearing Masks Part II: Ten years later http://mediamill.cla.umn.edu/mediamill/embed/26987

Impact of Family Conferencing Skills Workshop on Hospital Clinicians and Patients/Families

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This research aimed to measure the impact of family conferencing skills workshop on knowledge, skills and attitudes (KSA) of clinicians and their patients’/families’ satisfaction level. Research questions included (1) What is the impact of family conferencing training on clinicians’ KSA? (2) Does any improvement translate to increased patient/family satisfaction level? Well-conducted family conferences have been shown to be a significant adjunct of care in the hospital setting, yet many clinicians admit that they still lack the skills, or they are not convinced they make a difference to care, or they assume it is a natural talent to perform. We also lack systematic research showing evidence-based effectiveness of family conferencing which could possibly convince traditionally-trained clinicians to take effort to learn the skill as part of patient-centered care. The workshop was conducted among 20 consultants from various specialties in a tertiary medical center, where hospital policy includes requiring a family conference to be conducted by the attending physician whenever there are more than 3 different departments attending to a patient. Both qualitative and quantitative measures were used to compare pre- and post group performance of the participants, utilizing role plays using patient/family simulators. Qualitative outcome measures included comparing pre- and post-workshop outcome documentation forms; quantitative measures were in the form of scores in validated instruments, i.e. pre- and post-tests, process checklists and patient/family satisfaction surveys. Overall trend of the above-mentioned measures will be elucidated with regards to a pilot roll-out of the teaching module designed, lessons learned, and how further fine-tuning can be done in subsequent training workshops.
Individually Tailored Coaching: A Promising Approach for Remedial Teaching of Communication Skills?

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Introduction: General practice vocational trainees differ in their training needs and in their learning styles regarding their development of communication skills. This calls for an individually tailored approach in communication skills training, especially for those trainees that have been recognized as poor communicators.

Methods: We invited a group of 18 students that scored low on a communication OSCE at the end of the first year of general practice vocational training. The coaching started with an educational assessment interview in which the trainees could choose their own goals. Based on this interview an individually tailored coaching process was planned in an educational contract. We offered the trainees a wide range of methods e.g. role-playing with a tutor, having feedback on videos, reading, self-assessment, patient feedback, etc. After 4-5 months of coaching the project was evaluated by inviting participating trainees to a semi-structured interview, whereas coaches filled in a 13-questions e-mail questionnaire. Answers to both queries were investigated by content analysis.

Program evaluation: Drop out was considerable and for some we got an explanation: it had to do with personal priority choices or by trainee-coach interaction problems. Trainees that participated during the whole program highly appreciated the coaching except for the subscription of an educational contract. There was a substantial difference in the methods chosen by different trainees, confirming the advantage of an individually tailored approach. Bottlenecks had to do with the training practices, the trainee-coach relationship, the introduction of the program and time management.

Discussion/Implications: Individualized coaching in the remedial teaching of communication skills seems to be promising but diverse threats need to be considered. Threats are related to drop out of trainees, the trainee-coach relationship, the (non)involvement of the practice trainers and time constraints. Further research is recommended to better understand the drop out phenomenon.

Motivational Interviewing: Teaching Medical Undergraduates Key Skills to Facilitate Health Behaviour Change

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Introduction: Motivational Interviewing (MI) can promote behaviour change in healthcare settings and outperforms traditional ‘advice giving’, provided that practitioners adhere to the ‘spirit’ of MI. Doctors may benefit from understanding the efficacy and philosophy of MI and from being taught key communication skills associated with the MI. Early introduction to MI, and assessment of competency, sits well within a patient-centred communication curriculum for undergraduate medical students. The teaching aims to introduce students to fundamental principles and skills, which can be transferred and applied to consultations about different health behaviours.

Instructional and Assessment Methods: Three consecutive cohorts of undergraduate medical students in their 2nd/3rd year (n=approx. 300 per cohort) attended a 1.5 hour workshop. This included didactic elements (research evidence, principles of MI), a brief filmed consultation utilising MI and experiential learning (i.e. practising a guiding style consultation, eliciting change talk). Students were assessed on these key skills in the year-end Objective Structured Clinical Examination (OSCE). Expert examiners received detailed briefing on the specific skills taught.

Evaluation results: Relevant communication skills and effective MI consultation style were assessed over the three consecutive years, with each OSCE focusing on different health behaviours, i.e. smoking cessation, effective diabetic control, and weight loss. Examiner ratings of communication skills, focussing on both the process and the content of the consultation, will be presented. OSCE failure rates for each assessment year will be compared.

Discussion/Implications: Previous data show that medical students can develop and implement basic communication skills appropriate for MI. We will explore whether these skills transfer to consultations about different health behaviours. Although talking about behaviour change presents a challenge for undergraduate medical students, raising awareness of the benefits of MI early in the training of doctors may have a positive impact on their attitude and development of a guiding consultation style.

Technology and Social Media

Virtual Training Program Offered by Healthcare Professionals to Family Caregivers of Vulnerable Elderly

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Information and communication technology is being used more and more in the healthcare field. However, not many Web-based training programs also include coaching from a healthcare professional. In order to support family caregivers of seniors with impaired autonomy, the team at the Desjardins Research Chair in Nursing Care for Seniors and Their Families has developed and evaluated a psycho-educational stress management program.

The MeSSAGES program (online stress management learning support program) offers groups of 8 to 10 caregivers a seven-week online training program, with a healthcare professional as a coach, in which they learn the various steps of a stress management process using situations taken from their daily lives.

An overview will be given of the training program along with its effects on the perception of stress and the strategies learned by caregivers to cope with their daily problems. Practical examples of how this Web-based learning platform is used by participants and
their coach will be given to show the advantages and limits of the web-program.

The evaluation of this program shows that it is a promising online intervention tool for healthcare professionals who are interested in new information and communication technology. It also has benefits for various clienteles who are unable to get away from home to participate in a training program and who appreciate the flexibility it provides.

**The Effects of Medical-Institution Websites on Consumer Attitudes — Consumer: Log Data Analysis of an Experimental Website**

**Authors:** Chihiro Morito, Kyoto Sangyo University
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**Introduction:** As consumers receive services, they evaluate various aspects of, and form attitudes towards, the services and the service provider. We examined consumers’ search activity and attitudes by analyzing the log data of an experimental website and a questionnaire. Our results reveal how consumers’ evaluation of a medical institution is affected by the institution’s website.

**Methods:** Three versions of the website were prepared; version A contained mostly subjective information, version B contained mostly objective information, and version C contained both subjective and objective information. All three versions consisted of three pages: the main page, introduction of the clinic director and staff, and information for patients. The subjects of this study were 603 monitors. Comparisons were made between heavy and light users of the Internet, and between those with and without chronic illnesses.

**Results:** Irrespective of their past experiences with medical services, consumers indicated that information about the ease of consulting a doctor (making appointments, clinic hours, wait times) and information about cost were essential. Frequent Web users used medical-institution websites as their primary source of information on medical institutions, and family and friends as their secondary source. By contrast, the primary source for non-Web users was family and friends, and their secondary source was reputations. Comparing versions A, B, and C of the website, significant differences were observed regarding consumers’ memory of each of the three pages; their evaluation of the understandability, likeability, trustworthiness of the website, and their willingness to consult a doctor at that facility.

**Implications:** Objective information has a more positive effect on consumers’ memory and the understandability of the website than largely text-based subjective information. Consumers’ evaluation of a medical institution and their willingness to make an appointment at the institution are closely tied to their evaluation of the institution’s website.

**Weighing In: A Comparison of Communication Strategies Used in Pro-anorexia and Weight Loss Online Discussion Boards**

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**Introduction/Objectives:** Obesity and Anorexia Nervosa (AN) are opposite ends on the metaphorical scale; and both cause a multitude of serious health problems. This study aims to investigate whether a pro-anorexia online discussion group and a weight loss online discussion group share any similar communication strategies to achieve their similar goal—to lose weight.

**Methods:** Two coders used a theory-based coding schema developed from the Social Cognitive Theory (identification, supportive communication, vicarious learning, self-efficacy, negative self-efficacy, personal experience, and other) to compare the website Pro-An Nation, a popular international pro-anorexia discussion board, to WebMD’s diet community discussion board. Code frequencies were compared to assess whether the communication strategies used by participants differed per website and what types of communication were predominantly used to develop and maintain the online social community.

**Results:** Although weight loss was the desired outcome for both groups, the predominant communication strategy differed. The pro-anorexia online community predominantly used supportive communication, such as “Everything will be ok” (46%), while the weight loss community predominantly used vicarious learning, such as “What do you do when you get a craving?” (51%).

**Discussion/Implications:** Study results indicate that even though both online communities have a similar goal, different communication strategies are employed to reach that goal. The implications of this research are multiple. AN is increasingly understood as a mental illness, so supportive communication strategies, such as an online forum with a counselor, should be considered as a treatment option. Weight loss is still communicated as an individual pursuit, attainable if one follows the advice of others. Clinicians and health practitioners using e-health such as online discussion boards to promote healthy body weight for individuals who are overweight or diagnosed with AN should utilize the identified communication strategies.
Behavior and Adherence

Attitudes Toward ARV Adherence in Resource Limited Settings — Limitations of Strict Adherence Policies in Dominican Republic

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Introduction: Although the Dominican Republic government has been providing antiretrovirals (ARVs) free of charge since 2004, recent WHO estimates found that only 47% of HIV positive Dominicans who fit guidelines for ARVs are in treatment. This number is lower than in countries of similar GDP and region.

Methods: Qualitative study conducted at the CEDI public clinic in Santiago, Dominican Republic to explore how doctor patient communication and clinic policies affect community adherence rates to ARVs. The investigator audio recorded fifty-three medical visits and conducted post-visit interviews, including semi-structured and structured elements, with each patient. Interviews were transcribed and coded for themes.

Results: Scaled measures showed uniformly positive patient ratings of physician care and a patient population strongly motivated to medication adherence. However in interviews, patients expressed ambivalence concerning the clinic’s strict policy towards non-adherence. Patients who abandoned treatment were subject to a difficult reinstatement process involving waiting periods and psychological evaluation. We find that the CEDI clinic serves highly motivated patients well by fostering patient empowerment and encouraging personal responsibility. Such emphasis on strict adherence, however, may exclude patients with limited health education, minimal social and financial supports, and concomitant histories of substance abuse. This is particularly true given patient reports of prevailing stigma and discrimination towards Dominicans living with HIV.

Implications: We hypothesize that the excluded patients are those most at risk of transmitting the virus through drug use, unprotected sex or vertical transmission and that more inclusive models of care might have a greater impact on treatment rates and incidence of HIV. Comparison to adherence policies in other developing nations would further clarify their impact. Connections to attendance “no-show” policies in U.S. low-income clinics may also be drawn, with implications nationally for improving delivery of care in underserved settings and accommodating high-risk populations.

Patients’ Compliance in the Execution of the Exercises Stress Test — the Role of Communication Skills

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Introduction: The communication between health care professionals and patients is crucial to the establishment of a cooperative and thrusting relationship and contributes to improve health outcomes. Patient-centered strategies are associated with enhanced patient’s adherence and satisfaction in clinical interactions. Few studies however addressed the impact of communications skills in compliance to diagnostic and preventive exams, common procedures requiring the patient’s collaboration. The exercise stress test (EST) is a useful instrument for the diagnosis and prognosis of cardiovascular pathologies, and a screening tool for coronary artery disease. To be conclusive the test needs to be a maximal stress test, dependent on the patient motivation and compliance. The present work studied patient’s satisfaction and the effect of specific communication strategies in the execution of the EST, specifically exam length, following an experimental, prospective design. From a pool of 300 consecutive patients scheduled for EST, 265 patients were randomly divided in four groups: the intervention groups 1, 2, and 3 in which the participants were submitted to different standardized experimental procedures and the control group submitted to the routine procedure. Experimental procedures included patient standing up or sitting down (group 1 and 2) during exam instructions and patient sitting down plus a final open question eliciting doubts (group 3). Groups possessed similar sociodemographic and clinical characteristics. Patients included in group 2 and 3 presented statistically significantly larger exam length (p=0.00), representing a better compliance. Patient’s satisfaction was identical in the four groups. In conclusion, basic communication strategies are associated with a better performance on the EST, enhancing its accuracy. Present results underscore the advantage of feasible and time imperceptible communication skills in eliciting patient’s compliance with screening and diagnostic exams.

Keywords: communication skills; patient centered communication; exercise stress test; patient satisfaction

Compliance and Adherence in Pediatric Oncohaematology in Poland

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Introduction: Implementation of a therapeutic plan requires the doctor and the patient to work together. For adults, adherence involves a relationship between two people, whereas for paediatric
patients it also involves the child’s parents. The behaviour of a parent and his or her beliefs about the therapy significantly affect the therapeutic process.

**Purpose of the study:** The purpose of the study was to analyse the factors which affect the following of therapeutic recommendations in paediatric oncohematology.

**Material and methods:** The study covered 56 patients (37 in-patients and 19 out-patients). 51 parents of children below 16 and five patients above 16 set out to complete the survey. The survey was an anonymous questionnaire prepared by the author.

**Findings:**
1. The causes of lack of adherence in the study group were: absent-mindedness (27%), high drug price (13%), dislike of the drug resulting from the form of its administration (enema, injections) (13%), concern about adverse effects of drugs (7%), improved health and well-being of the child (7%), emotional barrier (7%), lack of confidence in the effectiveness of the prescribed drug (6%).
2. Parents play an important role in the shaping of attitudes and behaviours relating to a therapy.
   - Parents with higher education have a greater awareness of the need to discuss the therapy with the child.
   - Parents’ attitude to the child’s contact with the doctor changes with parents’ age. Information communicated to children where doctor-patient communications are via parents above 30 is restricted.
3. Strict following of drug dosage recommendations is understood differently by the parents and the patients. The parents understand the strict following of recommendations as adherence, whereas with the patients compliance prevails.

**Conclusions:** On-going contact between the parents and the doctor, correct relationship between the doctor and the treated child, proper communication of therapeutic information, and simplification of the drug scheme may contribute to improved adherence and improved therapy outcome in paediatric oncohematology.

**Keywords:** compliance; adherence; following therapeutic recommendations; following doctor’s recommendations

**Ladies on the Go! 10,000 Steps a Day**

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**Context:** Call2Health is an intervention to help African-American women improve their diabetes self-care. Patients were randomized into one of two study arms: daily text message only or daily text message + group sessions. Group participants increased their daily physical activity by walking and wearing pedometers. Although there are numerous appropriate, quality resources available to encourage healthy eating and the ins and outs of daily diabetes care, we found nothing suitable that addressed the benefits of walking.

**Description of Practice Innovation:** We produced a 6 ½-minute video, *Ladies on the Go! 10,000 Steps a Day*. Call2Health group members (patients) rewrote the script so that it more strongly emphasized the social aspects of walking and the role walking could play in families. The film stars several of our study participants and their children, in addition to two experts. The physician expert shares the health benefits of walking for diabetics and women in general; the fitness expert focuses on strategies patients can use to build more steps into their daily activity. The film was directed by a public television crew, and we filmed scenes in locations suggested by our patients.

**Impact:** Our video is a culturally appropriate tool to support African-American women in their diabetes care and general health goals. It concisely details the benefits of walking and provides strategies for making walking fun and accessible to lower-income women. The video is posted on YouTube, and we are disseminating the film to health departments, clinics, and professional organizations. The ladies in the film have been invited to participate as role models in a community obesity prevention project.

**Discussion:** By partnering with our patients, we created a high quality, culturally-appropriate tool to improve diabetes self-care, specifically daily exercise levels. Because of their pride in their film, patients are sharing it with friends and family, potentially increasing its impact.

**Learning from Patients: Identifying Blood Pressure Control Strategies used by Patients with Successfully Controlled BP**

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**Introduction/Objectives:** Hypertension represents a pervasive, dangerous condition for those with poor control, particularly in the African-American community. Despite treatment advances, patient adherence remains problematic. Patients who have successfully controlled their blood pressure (BP) may have important management strategies to share. Therefore, we sought to identify patients’ successful BP control strategies, to be used in a larger intervention.

**Methods:** Surveys were mailed to 1,500 African-American patients, identified in Veteran Affairs Hospital administrative data, who had achieved BP control in the past year. Participants were asked to select the two most important things they do to control their BP
and to briefly describe a “crisis or Aha! moment,” when they realized they needed to do something different to control their BP. Frequencies were calculated and qualitative responses were analyzed using thematic analysis techniques.

**Results:** The 149 respondents were older (mean, 62 years), male (85%), African-American Veterans, and representative of the target intervention population; most reported some college (54%). Taking medication was the most commonly reported strategy (68%); watching salt intake (35%), exercising (23%), talking to a doctor (17%), and avoiding stress (17%), were also reported. More than a quarter (28%) wrote in additional strategies, such as activities (fishing, basketball), weight loss, and specific dietary changes (eating fruits and vegetables, reducing pork). About 81% included “Aha!” moments, which included personal health events, experiencing dizziness, interactions with providers, initiation of behavior change, and incorporation of healthy habits.

**Implications/Discussion:** Patient-identified strategies may resonate with other patients, especially since provider interactions rank poorly among successful BP control strategies. While medication adherence was important, so were other strategies patients noted, such as extracurricular activities not included as “exercise,” and specific dietary changes. Providers may be able to capitalize on events patients who have successfully controlled BP identify as salient to motivate behavior change in patients with uncontrolled BP.

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**Cancer Communication**

The Role of Age in Cancer Patients’ Information and Communication Needs, Information Source Usage and Knowledge of Chemotherapy

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**Background:** Cancer is frequently a disease of older adults. Understanding older cancer patients’ (unfulfilled) information and communication needs is essential to improve treatment knowledge and to achieve optimal outcomes. Knowledge is considered a prerequisite for behavior, such as self-management. Little is known about older cancer patients’ unfulfilled information and communication needs, their information source usage and the relationship of these factors with knowledge. This study aims to investigate age differences in unfulfilled information and communication needs, information source usage and knowledge of chemotherapy. In addition, a model is tested including factors, based on theory and previous research, which might influence the level of chemotherapy knowledge, next to age.

**Method:** 1074 chemotherapy patients (273 > 65 years) completed an online questionnaire. The QUOTEchemo was used to measure (unfulfilled) information and communication needs. Information source usage and knowledge were measured with resp. 17 resp. 33 items.

**Results:** Results showed that, both in younger and in older chemotherapy patients, discussing ‘Realistic expectations’ (e.g., prognosis), ‘Rehabilitation information’ (e.g., dealing with side-effects at home) and ‘Interpersonal communication’ (e.g., attention for significant others) were the most prevalent unfulfilled needs. Older cancer patients reported more unfulfilled needs in ‘Affective communication’ than younger ones. They also reported a lower usage of the ‘Internet’, ‘Other patients’ and ‘Patient association’. Moreover, older patients had less chemotherapy knowledge than younger patients. When testing the model, patients with more unfulfilled information and communication needs had less chemotherapy knowledge than patients who were satisfied with the extent to which their information and communication needs were met.

**Conclusion:** Meeting information and communication needs of older cancer patients is a prerequisite for good information provision about chemotherapy and leads to more knowledge. The results of this study provide guidance to improve patient education about chemotherapy and adjust the information to personal characteristics and existing knowledge.

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**The Oncologists’ View on the Importance of Patient-Physician Relationship for Treatment Outcomes**

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**Introduction:** Whilst much is known to communication needs of cancer patients and to patients’ perceptions of their patient-physician-relationship, little is known to the oncologists’ view on the importance of a trusting alliance to their patients in the course of cancer treatment. Different theoretical models suggest that communication can “heal”; i.e. has the potential to influence treatment and outcomes. The present analysis was conducted to improve our knowledge of oncologists’ view on the importance of a trusting relationship between patients and physicians for patients’ treatment and outcomes of cancer therapy.

**Methods:** Our analysis is part of the WIN ON project (Working conditions in oncology). WIN ON is a German interdisciplinary prospective multicenter study examining the effects of working conditions of private practice oncologists on physician-patient communication and patient reported outcomes. For the present question, we analyze qualitative data drawn from semi-structured audiotaped and fully transcribed interviews with private practice oncologists. Data were evaluated using content analysis.

**Results:** This is work in progress. Our preliminary results show that for oncologists, a trusting patient-physician-relationship is an important prerequisite for successful cancer treatment in terms of open communication, adjustment of treatment to patients’ needs, compliance, control of adverse events, activation of patient’s resources, patients’ treatment confidence, reduction of patients’ anxiety, inclusion of family and caregiver needs and coping efforts. Complete results will be presented at the conference.
Implications: Our results will allow us to gain a deeper understanding of the importance and effects of a trustful patient-physician-relationship in the course of cancer treatment. The findings will serve as complement to existing theoretical models and empirical findings to the effect of a successful patient-physician communication on treatment outcomes in cancer care.

Determinants and Consequences of Interruptions in the Oncology Encounter

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Introduction: Interruptions decrease performance and can cause human errors. However, only a limited number of studies of interruptions exist in the domain of healthcare. Especially in the initial oncology encounter with diagnosis and treatment recommendations being a central issue, a quiet and undisturbed atmosphere is of particular importance to establish a trustful patient-physician-relationship and to allow a successful communication. The aim of this study is to examine types, reasons, frequencies and outcomes of interruptions in private-practice oncology during the initial clinical encounter.

Methods: The work is part of the WIN ON-project (Working Conditions in Oncology). This is an interdisciplinary prospective survey starting in 2012 throughout Germany to examine the effects of private-practice oncologists’ working conditions on their communication with patients and on patient-reported outcomes. For the present analysis, data from standardized physician and patient surveys pre- and post-consultation will be merged.

Results: This is work in progress. Results will be presented at the conference.

Implications: Based on our results structure- and process-based practice implications can be identified. The next step will be to design and implement interventions that address the working conditions of private practice oncologists. Those interventions will be evaluated with regard to their impact on the processes and outcomes of patient-physician-interaction.

Job Stressors and Resources for Communication with Cancer Patients — the Oncologist’s View

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Background: This exploratory study was designed to examine which job stressors or resources of oncologists affect the communication process among private-practice oncologists (PPOs) and their patients. In the second step, their influence on physician-patient communication as perceived by oncologists was analyzed.

Method: Within the qualitative study of the WIN ON-research project (Working Conditions in Oncology), semi-structured interviews with 11 PPOs in Germany were conducted. The sampling procedure was carried out by purposeful sampling criteria - region, sex, age and type of practice. Sampling was performed in this way since differences were expected for those features. As part of an iterative process, recruitment and data analysis took place simultaneously until no new essential information was expected to emerge. The data was evaluated using content analysis.

Results: A dysfunctional workflow (e.g. emergency cases), impaired cooperation with external providers (e.g. a lack of support), poor collaboration with colleagues and co-workers and disturbances during medical encounters seem to influence the oncologists’ level of stress and communication with their patients, as perceived by the PPOs themselves. In contrast, good time management, a well-functioning cooperation with general practitioners, hospitals, and other specialists, and well-educated co-workers are perceived as helpful for preventing oncologists’ stress, therefore influencing the communication process in a positive way.

Discussion/Implication: The interviewed oncologists mentioned job stressors and resources which influence communication with their patients. Oncologists that establish external resources, such as a good collaboration with external providers, as well as individual and organizational coping capacities, are better equipped to deal with time pressures and stress.

Within this study, we found some interventions named by oncologists themselves to manage their job stress at the organizational level. Future research should examine these and other interventions more deeply and concentrate stress research at the individual and organizational level.
Exploring Shared Decision Making for Cancer Patients

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Introduction: Shared decision making (SDM) is advocated as ideal in medical communication. However, not SDM per se but matching patients’ preference to actual decision making has been discussed to contribute to patients’ satisfaction (Gattelari et al., 2001, among others). Still the research findings on the matching are not consistent: some indicate improvement of patients’ satisfaction, and the others do not.

Methods: Internet survey to 619 cancer patients (male:310; female:309) who had explanation on chemotherapy was conducted (the population includes those who actually received chemotherapy) to examine whether a match between patients’ preference and actual decision making contribute to patients’ satisfaction, and to explore the characteristics of medical communication for the patients whose preference matches to actual decision making.

Results:
(1) 33.1%, 55.1%, and 11.8% of the patients preferred shared, physician-centered and patient-centered decision making, respectively (actual ways of decision making are 36.1%, 46.7%, and 17.2%).
(2) How treatment plans are negotiated do not affect patients’ satisfaction (F(2,609)=1.608,p=0.201).
(3) A match between patients’ preference and actual decision making makes the difference on patients’ satisfaction (t(615)=2.284,p=0.0227).
(4) There are no statistical differences of patients’ satisfaction among three ways of matched decision making (F(2,428)=1.808,p=0.165).
(5) Matched SDM patients who received chemotherapy are more satisfied than those who did not (t(228)=2.284,p=0.0227).
(6) Patients involving matched physician-centered decision making collect less medical information (F(2,428)=13.24,p=2.64e-06), and think that they are less explained than those of matched shared and patient-centered (F(2,428)=12.94,p=3.5e-06).

Discussion: Patients’ satisfaction for physician-centered decision making cannot be accounted for based on medical information and physicians’ explanation. Whether the contributing factors are particular to physician-centered or can be utilized for improving patients’ satisfaction even for SDM or patient-centered should be addressed in further study.

Ways to Improve Cancer Information and Support through Collaboration — an International Perspective

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Nearly two-thirds of cancer survivors are actively seeking information from any source throughout the course of their cancer journey. Cancer Information Services (CIS) provide this information free of charge via telephone, face-to-face counseling, e-mail, Internet and other channels. The International Cancer Information Service Group (ICISG) is a worldwide network that promotes collaborations, assists organizations to develop a CIS, and is a forum for exchange of best practices for the benefit of cancer patients and their families. ICISG has 83 member organizations in 52 countries, including Europe with 30 CIS programs in 26 countries. This presentation will provide an analysis of the cancer information and communication needs of Europeans, and how CIS’s meet these needs. Goal of the network is to develop strategies and quality standards in the provision of cancer information throughout Europe, to make sure that in the long run cancer patients in every country in Europe get equal access to up-to-date and high-quality information, treatment and care. A survey of European cancer information services was conducted. Survey results (from more than 250,000 inquiries) show clearly that users need trustworthy, evidence-based and customized information which is communicated with empathy and focus on their individual situation. These data, ways to meet these needs, examples of the challenges and best practice will be presented. CIS’s have a common agenda and goals, beyond differences in culture, structure and resources. Their collaborative efforts towards informing, supporting and empowering cancer patients and their families can be an example for other regions of the world. Moreover, by linking all available resources and initiating collaborations and networks, CIS’s have the potential to serve as reference centers for cancer information in their countries and across national borders, thus supporting cancer control and contributing to the improvement of the situation of cancer patients and their families.

Communication and Emotion
Lots of Doctors Have Lost their Sense of Caring - They Would Rather do What they Want for You and Be Done: Caucasian and Hispanic/Latina Women’s Communication Style Preferences with Physicians

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Introduction/Objective: Much research in patient-provider communication explores how race/ethnicity influences the clinical encounter. Studies have investigated racial and ethnic concordance, biases, and perceptions from both the patient and the physician’s perspective (e.g., Cooper-Patrick et al., 1999; Street, O’Malley, Cooper, & Haidet, 2008). In addition, specifically examining women’s perspectives about health are important, as it influences how they interact with healthcare providers, and the information that they choose to share and not to share within the clinical encounter (Hunt & de Voga, 2005). As such, this purpose of this paper was to explore Caucasian and Hispanic/Latina women’s perceptions of their providers’ communication.

Methods: Fourteen, semi-structured interviews were conducted with Caucasian and Hispanic/Latina women. Interviews ranged between 15 minutes and an hour. Interviews were recorded and transcribed. The data were analyzed using the constant comparison approach,
creating and developing themes based on the transcriptions (Lindlof & Taylor, 2011).

Results: Overall, both Caucasian and Hispanic/Latina women’s perceptions of the “ideal” physician were influenced by the physician’s communicative style (characteristics and behaviors) rather than their own race/ethnicity. The women described a want for their physician to be professional, honest, caring, and supportive. Additionally, a physician who provides detailed information, checks for understanding, builds partnerships, and listens to their experiences and opinions was the most effective and preferable communicator.

Discussion/Implications: By tailoring communication to patients based on race/ethnicity may not the only important component when communicating with patients. In other words, this study demonstrates a desire from female patients to move away from using race/ethnicity stereotypes to communicate with patients and instead focus on the characteristics of the physician and their type of communication style.

Patient and Loved Ones’ Emotional Expressions in Palliative Care Decision-making Consultations: A Direct Observation Study

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Background: Seriously ill patients and their family members seen by palliative care consultants are faced with a myriad of decisions about their future. Because these decisions are so complex, they are often accompanied with negative emotions. When these emotions arise, they become empathic opportunities for providers. One of the important tasks of palliative providers is to address these negative emotions through empathy.

Objectives: To describe the types and frequency of negative emotions patients and their loved ones express and the provider responses to those emotions during PC decision-making consultations with seriously ill hospitalized patients.

Methods: We audio-recorded 71 sequential inpatient palliative care decision-making consultations (initial visit). Conversations were coded for evidence of the presence of negative emotions and how providers responded to those emotions using reliable and established methods.

Results: A total of 71.1% percent of conversations contained at least one emotion. The per-conversation frequency of emotions ranged from 1 to 10. Anxiety/fear were the most frequently encountered emotions (48.4%) followed by sadness (35.5%) and anger/frustration (16.1%). Emotions were expressed directly (49.7%) and indirectly (50.3%) at the same rate. The majority of expressed emotions (53.6%) were centered on the patient but the loved ones’ own emotions were also prevalent (41.9%). Most of the emotions were moderate in intensity (65.8%) followed by strong (20.7%) and mild (13.5%). Thirty-nine percent of emotions were elicited and 61% were spontaneous. The majority of emotions were followed by an empathic response (75.7%) or with medical content (21.9%), very few were ignored (1.3%).

Conclusions: Patients newly referred to palliative care face complex and difficult decisions. These decisions are often accompanied with many overwhelming emotions. The results of this study are encouraging for palliative care – empathy is at the forefront of providers’ responses to patients’ and loved ones’ emotions.

Physicians’ Intense Emotions in the Presence of Patients

Authors: Irene Carvalho, University of Porto
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Purpose: Clinical encounters are contexts prone to eliciting intense emotions in both the patient and the physician. While research has focused on patients’ emotions, less is known about doctors’ emotional reactions. Yet, the way physicians manage their own emotions when they are with their patients can affect both doctor and patient, the climate of the medical encounter, and the doctor-patient relationship altogether. The aim of this study is to explore physicians’ intense emotions arising in the presence of their patients and their impact on the doctor-patient relationship.

Method: A total of 127 physicians from several specialties (mean age=37.82; SD=12.81) responded to a self-report survey on emotional reactions built from a literature review. Participants were contacted through a snow-ball sampling procedure and via institutional e-mails.

Results: Fifty-two physicians (41.94%) reported experiencing intense emotions daily and monthly in their clinical practice with patients. Most reported negative intense emotions that included sadness, anxiety or fear, powerlessness, anger, disappointment, repulse, guilt and shame. Positive emotions were relief and happiness. Other emotions included compassion. Most physicians did not control the emotion completely at the moment it emerged and displayed it to patients in variable ways. Still, physicians reported using cognitive and behavioral coping strategies to deal with the emotion when it emerged. Forty-seven physicians (52.80%) considered that these emotions did not have an impact in their relationship with that patient at the moment. Only nine (10.10%) reported that the emotional reaction had a negative impact. Thirty-three (37.10%) considered that the emotion had a positive impact at the moment. Twenty-two (42.30%) participants reported that the impact of the episode in their relationship with the patient extended at future interactions with that patient.

Conclusions: Physicians’ strong emotions are frequent in their daily practice in the presence of their patients. Since they impact the doctor-patient relationship in a considerable number of cases, they are an important focus of future studies.
An 8-week Compassion Training Program for Health Professionals

Author: Richard Pinckney, University of Vermont

Introduction: Compassion is an established requisite for health care practitioners. However, there is very little available in the medical curriculum for learning the important skills related to compassion. An 8-week compassion training program was developed and piloted on medical students, attending physicians, nurses, and chaplains. The objectives were to 1.) Understand the various elements of compassionate care, 2.) Know fundamentals of compassionate communication and action, 3.) Understand common barriers to compassionate care and how to mitigate them.

Instructional methods: The workshop series utilized small group discussion, brief didactics integrated into the discussion, and group exercises. Using this strategy personal and group reflection was integrated with compassion content and skills from cognitive behavioral therapy, mindfulness, non-violent communication, loving-kindness, and other paradigms. The small groups met every 1-2 weeks for an hour, with compassion homework between sessions.

Program evaluation results: Six small groups of 5-15 learners participated in the training. Satisfaction with the series was high. Compassion of participants improved as measured by self-perception measured on a 10-point Likert scale.

Discussion: A compassion training program has been well received and improved self-perceived compassion. Further study of the impact of this training on patient care would further validate the usefulness of this training and enhance acceptance for broad dissemination.

Decision Making

Does Video Recording Clinical Encounters Affect the Efficacy of Decision Aids: An Encounter-level Meta-analysis

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Introduction: In our randomized trials of decision aids, our group video records encounters of the patient-clinician interaction to evaluate the impact of the decision aid (DA) and compare to usual care (UC). Participants can decline video recording (VR) or VR could not be available for technical reasons leaving us with a portion of encounters recorded. We sought to determine to what extent VR could affect outcomes of interest and if there was a differentiating effect of VR for DA vs. UC.

Methods: We conducted an encounter-level meta-analysis of our practice-based randomized trials of DA vs. usual care. Analysis was conducted using a generalized linear mixed model to estimate the effect of VR on the outcomes of interest (knowledge, satisfaction, adherence to decision, decision conflict, and knowledge of risk). All models were adjusted for fixed effects of VR, study arm, income, age and arm/VR and the random effect of study.

Results: 527 (68%) of 775 encounters in 7 trials were VR, with more recorded in DA arms (54% vs. 46% in the usual care arm). Encounters were similar in patient demographic characteristics for VR vs. not, except higher income patients were more likely to have their encounters recorded (68% for >40k vs. 32% for <40k). Patients in VR encounters had higher post visit knowledge about options (P=0.05) and about risk (P=0.005), were similarly satisfied with the encounter and reported similar decisional comfort, and were less likely to adhere to their decision (P=0.023) than patients in nonVR encounters. Importantly, no differentiating effect of VR on DA vs. UC was found in any of the measured outcomes.

Implications: Video recording encounters does not appear to bias trials of decision aid efficacy.

Can Shared-Decision Making Improve Neonatal Intensive Care unit (NICU) Decisions?

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Introduction: Decisions about several interventions in the NICU (e.g., whether to resuscitate an extremely premature infant) can have lifelong consequences but often have to be made under conditions of uncertainty, emotional stress and time pressure, with parents ill-prepared to participate in decision-making. Improving clinician-parent communication and incorporating principles of shared-decision-making (SDM, widely used with adult patients) can potentially improve the quality of decision-making and parental satisfaction with care. We aimed to identify clinical situations that caused difficulty in decision-making, develop methods to reduce such difficulty, and determine whether principles of SDM can be applied in the NICU.

Methods: We conducted in-person interviews with 11 NICU clinicians (4 attending physicians, 3 residents, 1 fellow, and 3 nurse practitioners) at our institution. We also surveyed a convenience sample of 15 families of children discharged from our NICU.

Results: The key findings were: (1) Significant differences between clinicians and families about which decisions were considered difficult; (2) Lack of a formal process of decision-making and of identifying parental preferences; (3) Variation between clinicians in their approach to involving parents in decision-making; (4) Lack of understanding of principles of SDM by both clinicians and parents. Four areas for improved communication were identified: anticipatory
planning, information and education within the NICU, consistency and continuity of care, and emotional support for families.

**Discussion:** Our findings -- which are limited by a selective, small sample that excluded bedside nurses -- suggest that there is much room for improvement in NICU decision-making. Such improvement can be accomplished through a NICU program that has a standardized component applicable to all families (process of communication, information provided, use of decision aids) and a component customized for each family (preference identification, degree of preferred involvement in decision-making, communication formats).

**Equal Options — A Shared Decision: Development of a Decision Aid for Treatment Choice in Advanced Parkinson’s Disease**

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**Introduction:** In advanced Parkinson’s Disease (PD), evidence for first choice of treatment is lacking as no trial has compared the three available therapies directly. Therefore, therapy-selection should be personalized, requiring shared decision making (SDM) to enhance patient involvement. In our previous study professionals expressed a need for a decision aid (DA) to support this process. Current literature emphasizes that decision aids often lack a theoretical foundation. Here we describe the development of our DA and its theoretical foundation.

**Methods:** The process map of Elwyn et al(1) was used to develop the DA. Qualitative and quantitative data from professionals and patients provided information for the needs assessment. SDM models, decision-making theories plus general and PD specific cognitive decision processes from the literature gave input for the theoretical framework of the DA. Together with the needs assessment, evidence synthesis and brainstorm sessions, this resulted in a first prototype. The prototype was tested in several rounds by treated patients, treatment-naïve patients, neurologists, PD specialists with expertise on these treatments, PD nurse specialists, and a patient communication expert.

**Results:** Both patients and professionals expressed a need for equivalent treatment information. Relevant PD specific cognitive processes were impulsivity, reduced cognitive flexibility, and limited capacity to organize new information. Our qualitative data showed that patients often focus on one treatment, not searching for equivalent information on alternatives. Using the theoretical framework, strategies were build into the DA to reduce these possible biases in decision making.

**Discussion:** This DA has been developed based on current needs, evidence synthesis, decision-making theories applied to decision-making in advanced PD, and involving all stakeholders. In the next phase we will test the decision aid in an explorative cluster-randomised trial for feasibility, acceptability and efficacy.

1) Elwyn et al. How to develop web-based decision aids for patients: a process map. PEC. 2011

**Do Patients Have a Choice? Shared Decision Making in Advanced Parkinson’s Disease**

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**Introduction:** In advanced Parkinson’s Disease (PD), three therapies are available: deep brain stimulation, duodenal levodopa infusion, and subcutaneous apomorphine infusion. Evidence for first choice of treatment is lacking as no trial has compared these therapies directly. Therefore, therapy-selection should be personalized, requiring shared decision making (SDM) to stimulate active patient involvement. In this study we evaluated the current decision making process in advanced PD and the role of SDM.

**Methods:** Questionnaires on current decision making and SDM were developed based on our previous qualitative data and literature research. Questionnaires were sent to all registered Dutch neurologists (n=869) and PD nurse specialists (n=86) in the Netherlands. A convenience sample of patients who had undergone one of the treatments in the past three years (n=179) received a questionnaire. Patients were recruited through online requests and neurologists.

**Results:**
- **Neurologists:** 88% considered SDM useful and 54% said they regularly/always applied SDM for this decision, while 24% was not involved in this decision process. An important barrier to SDM was a lack of knowledge about all treatments, due to a lack of hands-on experience. 66% expressed a need for a decision aid.
- **PD nurse specialists:** 29% were actively involved in decision making while 36% gave information only. 79% expressed a need for a decision aid.

**Patients:**
- Just 40% were informed about all three options. The majority of patients (63%) would have preferred SDM for this treatment choice; 41% had actually experienced SDM and a small proportion was referred (11%). An important facilitator for SDM was trust between professional and patient.

**Discussion:** Professionals and patients have a very positive attitude towards SDM, however in practice it is not used optimally. It is important to increase equivalent information on all options and improve patient involvement. A decision aid can resolve this, stimulating SDM in advanced PD.
It’s the God Complex: Negotiation of Women’s Bodily Ownership and Expertise in Patient-Provider Interactions

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Introduction/Objectives: Scholars have termed shared decision-making "the crux of patient-centered care" because it can help empower patients to take an active role in their treatment regimen and improve patient self-efficacy and health outcomes (Edwards & Elwyn, 2009; Elwyn, Edwards, & Kinnersley, 1999; Saba et al., 2006). However, it has also been argued that shared decision-making "rarely happens, is hard to do and is not taught for many reasons" (Godolphin, 2009, p. 186). Thus, this project explores Hispanic/Latina and Caucasian’s women’s experiences with their physicians, specifically focusing on whether the participants’ experiential knowledge is valued in the shared decision-making process and the terms physicians use to describe their patients’ bodies and actions.

Methods: Fourteen in-depth, semi-structured interviews were conducted with Hispanic/Latina and Caucasian women. Interviews ranged between 15 minutes and an hour. Interviews were recorded and transcribed. The transcripts were analyzed using the constant comparison approach, and themes were created and developed (Lindlof & Taylor, 2011).

Results: Two central themes emerged from data analysis: denial of patients’ bodily expertise, and the re-construction of the historical pathologized, neurotic, female patient. The participants reported that their physicians denied their experiential knowledge and overlooked or rejected their feelings, emotions, and preferences during the decision-making process. Moreover, their bodies were discursively constructed negatively as deteriorating, lying, and overreacting beings.

Discussion/Implications: This study confirms that the language choices that physicians deploy when describing patients’ illnesses and making decisions have real, material implications for the patients’ self concepts and well being. The notion of privileging physicians’ scientific and biomedical expertise is still the medical norm at times, and physicians need to be more sensitive in honoring their patients’ experiential knowledge. These results support scholarship that suggests that shared decision-making is indeed a useful theoretical concept, but that it “rarely happens [and] is hard to do.”

Diabetes and Other Chronic Conditions

Barriers to Care and Personal Strategies: Patient Narratives of Managing their Diabetes

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Diabetes is a common chronic condition encountered in primary care, which relies greatly on the patient for optimal control of the disease. Diabetic patients are advised to make many changes in their lifestyle such as diet, exercise, taking medication, performing blood sugar controls and regular medical check-ups. This entails an educational and acceptance process, which the patient often had not foreseen. This research focuses on diabetic patients’ perspective of the barriers to care they encounter while caring for their chronic illness, and on the strategies they rely on to overcome them. Two groups of patients were selected from our primary care clinic: one with long-term adequate control of their diabetes (HbA1c<7%) and another with long-term insufficient control of their diabetes (HbA1c>8%). The choice of studying patients with a good control of their diabetes was based on the theory of positive deviance. Through better understanding strategies of patients with efficient control of their illness, these might offer clues that could be generalized to inform health care to other diabetic patients. 23 semi-structured individual interviews with patients were taped and transcribed, followed by qualitative thematic analysis. Results from these analyses will be presented, including comparisons between narratives of each group; implications for health care of diabetic patients in primary care will be discussed.

Linguistic Evaluation of Type 2 Diabetes Patients’ Voices to Develop Adherence—Promoting Communication Strategies

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Background: This study evaluated healthcare providers’ communication strategies according to type 2 diabetes patients’ psychosociolinguistic characteristics to improve adherence to prescribed medications and healthy behavior recommendations. An interdisciplinary team from linguistics, medicine, and communication developed a linguistic coding system to assess three psychosociolinguistic constructs related to adherence behavior: Locus of Control, Agency or Self-Efficacy, and Emotion (Connor et al., 2012; Clark et al., 2012; Antón et al., 2012). Studies using the system have shown demarcations of clearly identified codings of patient types as well as significant relationships between patient types and self-reported adher-
Ence (Connor et al., 2012). Subsequent analyses have explored using the system not only in predicting medication adherence but also in changing health behaviors (Clark et al., 2012; Antón et al., 2012).

**Objectives:** This research evaluated the feasibility of delivering tailored health messages in clinics to improve patient adherence to the critical behaviors in managing diabetes such as healthy eating, being active, taking medication, problem solving, reducing risks, and healthy coping.

**Methods:** Sixty type 2 diabetes patients in a rural U.S. Midwest clinic took a validated, 25-question instrument based on the above research and participated in focus groups to discuss and evaluate written and oral messages tailored to their profile outcomes (e.g., Internal Locus of Control + Positive Emotion or External Locus of Control + Negative Emotion). Four healthcare providers in the same clinic participated in the development and evaluation of the messages at each stage.

**Expected Results and Implications:** The results of the study will be discussed in terms of the translatability of tailored messages employing patient voices for intervention studies and clinical use. Because the linguistically-tailored messages are targeting behaviors in accordance with the American Association of Diabetes Educators recommendations, the results will also further strengthen the links between healthcare patient education and patient-provider communication.

**Empowering People with Type 2 Diabetes: Responses of Patients and Clinicians to an Intervention to Support Self-management**

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**Introduction:** The Co-creating Health programme aims to improve the health of people with long term conditions by enhancing their skills and confidence in self-management and fostering collaborative relationships with clinicians. Patients and clinicians are trained to identify and address mutually agreed goals in a patient-centred consultation.

This paper reports the results of a qualitative study of 5 primary care practices which underwent training to improve the care of patients with Type 2 diabetes.

**Method:** Fifty three patients and 42 clinicians (31 doctors and 11 nurses) attended training during the study period. The patient training comprised 5-7 weekly three hour sessions and the clinician training comprised 2-3 sessions (6 hours total). Training was delivered by one clinician and one lay tutor per course. Attendees were invited to participate in a telephone interview with an independent researcher to evaluate the course and its impact.

**Results:** Nineteen patients and 8 clinicians (7 doctors and 1 nurse) were interviewed. It proved difficult to recruit clinicians, and nurses were under-represented. The majority of patients (17/19) were positive about the course, particularly valuing knowledge about diabetes and diet, and the opportunity for social comparison. Six patients reported behaviour changes as a result of the course (e.g., writing down questions for the doctor), including three who reported a transformation in their approach to their diabetes. The response from clinicians was mixed, although several reported using strategies in their consultations. Clinicians cited lack of time and patient motivation as barriers to long term implementation.

**Discussion:** The programme aims to effect change by training patients and clinicians in a common approach, but the groups differed in perceived needs and desired outcomes. The course was more successful in promoting strategies than a sea change in approach, although it was valued by patients, who may have benefited from a longer term intervention.

**Patients’ Perspectives about Diabetes**

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**Introduction:** Diabetes is a chronic disease conditioned by patients’ perceptions, beliefs, myths and life experiences. Each person defines diabetes according to his own personal view. Understanding patients’ perspectives and perceptions about diabetes and the way they deal with the disease is very important to health care providers. The aim of this study consisted in knowing patients’ perspectives about diabetes.

**Methods:** We asked patients who came to diabetes consultations at APDP in October 2012 “What is Diabetes?” A qualitative study was conducted to analyze the perspectives.

**Results:** From the 100 participants with diabetes, 94 had type 2 diabetes, 42 were female. Average Age - 67 years. Diabetes evolution average - 17 years. Average HbA1c 7,6%.

43 participants did oral medication, 33 insulin therapy, 24 patients did both.

The main categories identified through the content analysis were related to the disease’s process (58%) namely about pathophysiological process - pancreas function disturbs, lack of insulin and high blood sugar level; diabetes severity, because diabetes is a silent disease that damages everything and is chronic.

15% of the patients referred the Diabetes treatment, mainly nutritional and the difficulties to eat what they prefer; 14% considered diabetes as boring and teasing.

10% of the participants referred that diabetes implies a lot of complications in all organs (eyes, feet, heart, hands). 3% answered that they didn’t know what diabetes was.

**Conclusions:** Most of the participants considered diabetes as a chronic process that disturbs insulin production with consequent high blood sugar level and severe health consequences related to diabetes complications. Other participants considered diabetes as boring and teasing and creating difficulties and forbidding them to eat what they prefer.
The presented study may be helpful for health care providers and contribute for a better understanding of patients’ perspectives and about what means to live with diabetes.

Difficulties Referred by People with Type 2 Diabetes

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Introduction One of therapeutic education goals is to know and understand the patients, taking into account their representations, needs and difficulties, in order to promote better adherence to treatment.

The aim of this study was to know which was the greatest difficulty felt by people with type 2 diabetes regarding to diabetes.

Methods: We asked patients who came to diabetes consultations at APDP in January 2012: “What is the greatest difficulty you feel about diabetes?”. A qualitative study was conducted.

Results: 44 participants type 2 diabetes, 25 were female. Average age - 66. Diabetes evolution average - 18 years. Average HbA1c 10%. 15 participants did insulin therapy, 1 did oral medication and 28 did both.

The main categories identified through the content analysis were related to Diabetes treatment (45%), according to self-monitoring (having to prick my finger costs a lot); self-control, because management is complicated; eating healthy, not eating sweets and always be snacking; starting insulin, daily treatment with insulin and physical activity.

22% of the participants considered that the greatest difficulty was related to late complications - since diabetes is a silent disease they were afraid of foot, eyes and kidney complications.

The difficulties related to acute complications were referred by 20% of the patients, namely fear of hypoglycemia and feeling bad with hyperglycemia and going to the hospital.

The discrimination in social life is referred by 4% of the participants and 9% named other aspects.

Conclusion: Most of the difficulties referred by people with diabetes cover the several areas of diabetes treatment - self monitoring, self control, insulin therapy and nutrition. Other difficulties are related to the fear of acute and late complications of diabetes.

This knowledge could allow professionals to have a better understanding of patients’ difficulties and to provide personalized care to their needs.

When Later Means Never: The Challenges of Psychiatrist Regarding Diagnostic Disclosure of Schizophrenia

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Introduction/objectives: Diagnosis disclosure and sharing of information to patients are key elements in patient-centered care and in respecting patient autonomy. In contrast to other fields of medical practice in which there is a growing tendency to share diagnostic information with patients this approach is less common in the mental health field. A limited number of studies exist about diagnosis disclosure in psychiatry, and deeper understanding is needed in this field. The present study addresses this issue by employing in-depth exploration to understand considerations of psychiatrists regarding the sharing of the diagnosis of Schizophrenia to patients and family members.

Method: A qualitative study that included 18 psychiatrists from hospital and mental-health community settings in Israel was conducted. Semi-structured interviews were obtained and audio-recorded. Transcripts were analyzed using a grounded theory approach.

Results: Interviews yielded rich accounts depicting psychiatrists’ tendencies to not disclose diagnostic information. A complex net of disclosure challenges was identified under three domains: 1. Characteristics of the Schizophrenia illness; 2. The doctor-patient/family relationship; and 3. Psychiatrists’ personal difficulties with the task. Ten subcategories were further identified across these domains.

Discussion/implications: A multi-layered model consisting of medical, relational, social and personal challenges depicts doubts that interact with psychiatrists’ tendencies to delay or not disclose Schizophrenia diagnoses. Major challenges include: doubts regarding the benefits of disclosure; concerns about therapeutic relationship and treatment adherence; stigmatic-pessimistic views; social-cultural considerations about patients/families; and psychiatrists’ emotional burden and their perceived need for self-protection. The current study stresses the need to develop guidelines and support psychiatrists, focused on all challenge aspects. These include: addressing stereotypes and prior knowledge and attitudes of psychiatrists patients and families about Schizophrenia, rehabilitation and recovery; enhancing awareness about patient, family and sociocultural sensitivity; and providing emotional support and specific training and supervision on the matter of disclosure diagnosis.
Humanities

Enhancing Humanism in Medical Education: A Multidisciplinary Analysis of a Medical Case using Behavioral and Social Sciences

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Introduction with institutional context and educational objectives: Teaching medical humanities is becoming a more central component of medical education, however related courses are relatively unexplored and are criticized as devoid of clinical relevance. The same critiques appear in discussions over behavioral and social science (BSS) courses. To overcome these critiques this presentation focuses on a multidisciplinary analysis of a “real-life” medical case scenario by seven different scholars from five disciplines. The analysis exemplifies how the combination of these perspectives enhances understanding of the complexities of medical care, and the development of humane and holistically oriented medical professionals. This analysis is a part of an introductory, interdisciplinary course, entitled “humanistic aspects in medicine” at Tel-Aviv University School of Medicine.

Instructional: A “real-life” case was individually analyzed by seven educators from different BSS backgrounds, who co-teach the interdisciplinary course. The case features an 82 year-old woman (and her adult children) faced with the need to decide about her treatment and care, after being admitted to the surgical ward for an esophageal tumor.

Program evaluation results: The various disciplines discussed different concepts, biases, and habits of mind and behavior when dealing with elderly patients, uncertainty, and family members. Similarities and differences exist among the disciplines, e.g., communication focused on the multi-participant conversation and decision-making process; legal aspects cautioned against violating patients’ rights; and psychology cautioned against giving up and providing unsatisfactory medical care to an elderly patient.

Discussion/implications: The multidisciplinary analysis of this case contributes to the effort to re-contextualize medicine by identifying and illustrating the complexities, nuances, ambiguities, and possibilities when faced with real human beings. Each discipline provides substantial insight, but no single discipline managed to provide a holistic view by itself. Discussing a case allows the combination of theory and practice, and opens the mind and heart to noticing different angles within the complex phenomena of physician-patient-family relationships and decisions.

Can Physical Examination be Learned in an Art Museum?

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Objective: To enhance the physical examination and bedside diagnosis through an observation and humanistic experience at an art museum.

Methods: We established University of Florida College of Medicine’s 4th year medical student elective, The Art of Advanced Physical Diagnosis and Clinical Reasoning aimed at (1) providing a two week curriculum focusing on bedside diagnosis, (2) enhancing bedside observation and communication of the observations through peer teaching. Our elective course at the Harn Museum of Art incorporates an interdisciplinary humanities approach, mindfulness, reflection, visual thinking and communication of observations. 4th year students teach each other and also the 3rd year medical students using peer teaching concepts.

Prior to the Harn Museum experience, students are provided readings from literature, art analysis, and concepts from Rudolf Arnheim, Visual Thinking. Students independently explore the museum and choose a work of art. Using visualization, macro to micro viewpoint, they analyze and write a reflection on what they initially saw and what they further saw after looking at the art in detail. Reflections are shared while viewing the art, other students explore the work sharing what they see. A group discussion follows on how enhancing visual sense, pausing to pay attention and reflection improves what we see during the physical examination, in essence the patient as unique individual.

Results: We measured enthusiasm for bedside examination and teaching. Enthusiasm was high before the course and rose further following the two week elective. The students found that the experience at the bedside enhanced their ability to ‘see’ the patient utilizing focused attention during the observation exercise. They were better able to describe and communicate their observations. The experience in peer teaching helped the students gain expertise in teaching.

Conclusion: The physical examination is enhanced through the use of focused observation, mindfulness practice, reflection, and an interdisciplinary humanities approach.

Integrating Narrative, Film and Medical Readers Theater into Doctor of Physical Therapy and Medical School Curriculums

Author:
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Abstract: The Humanities serve a remarkable purpose in reminding us of our own humanity. In this way they can enhance the empathy, humility and self-awareness of students in the medical professions, who may be more focused on the science of medicine...
rather than the art of the profession. By including experiences with the humanities in the classroom, students can be reminded of their purposes for pursuing their professions and come to understand their own humanity better. The modalities of Narrative Medicine (Charon, 2001), Film (Brett-MacLean, 2010) and Medical Readers’ Theater (Savitt, 2002) have been utilized and developed as part of a Professional Communication course in the Doctor of Physical Therapy and a Capstone Course Selective in the School of Medicine at Duke University over the past 8 years, with qualitative evidence of positive impacts on students. The inclusion of these teaching strategies can be adapted to small and large groups in terms of format and content. The presentation of the teaching methods employed in these courses may be valuable for application in other medical professional programs. This oral or poster presentation will describe how the humanities were incorporated into these courses and will encourage discussion for use elsewhere in medical education.

References:

NOTE: Previously presented at pre-conference, Creating Space III, Canadian Conference on Medical Education, April 19-20, 2013, Quebec, Canada

Improvisation and Communication in Community Learning Sessions

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Second year students at the Northern Ontario School of Medicine (NOSM) spend two months in different rural communities. During this time, learners participate in four Community Learning Sessions (CLS). Typically, these sessions may be with pharmacists, chiropractors, dieticians, traditional healers or tele-ophthalmology visits.

The mandate of the Debajehmujig storytellers is to educate and share original creative expression with Native and Non-Native peoples and thereby vitalize Anishnaabeg culture, language and heritage.

We theorized that sessions with medical students and animators of Debajehmujig would provide an opportunity to enhance communication skills with patients and colleagues and to understand how arts organizations engage in the health of their communities. We describe a project where students working in four communities joined animators from Debajehmujig to explore themes of mental illness and social disadvantage.

Animators constructed complex characters with themes of anxiety, depression and cognitive decline. The animators were asked to improvise within a set of parameters in six simulated clinic encounters. The social context for each condition was constructed with special consideration given to cross cultural issues in Northern health care and regional economic realities. Scenario stations were constructed to accommodate eight medical students working in pairs. Following each of the interviews, the student partner summarized the interaction using the Situation-Background-Assessment-Recommendation (SBAR) tool, and the animator provided feedback. In two additional sessions, students participated in communication exercises as used by the animators for enhancing communication and self-awareness.

Students and animators alike enthusiastically participated in this pilot project. Haidet in the Annals of Family Medicine (2007) proposed that “the traditions of jazz improvisation can inform efforts to research and teach medical interviewing by fostering a contextualized view of patient-physician communication.” The opportunity to forego standardized patients for improvisational interactions may deepen learning through a greater intensity of patient interaction.

Health Systems and Interprofessional Communication

ARTful Wilderness Medicine and the Impact on Interprofessional Communication

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WildERMed is a three-day outdoor wilderness medicine course in Northern Ontario. Participants from medical, health and outdoor leadership backgrounds collaborate while learning survival, navigational and medical skills. Instructional strategies include didactic sessions, workshops and field exercises, culminating in five hours of navigation with patient simulation scenarios.

Our hypothesis is that learning together in a non-traditional setting, employing areas of study not usually forming part of the practitioners’ area of comfort will help professionals from different disciplines to enhance Interprofessional competencies.

Since “forum theatre can provide a practical, pedagogically effective approach to the teaching and learning of communication skills” (Middlewick, Y., et al 2011), a production with a context-related plot based on calamities in a remote environment was performed early in the course with the intent to humorously stimulate lateral thinking. The forum theatre animators from Debajehmujig, an experienced First Nations storytelling company, also performed as simulated patients. As teams navigated between scenarios, they made audio diaries in response to pre-set questions posed regarding collaboration, communication and the impact of the live scenarios. Participants completed the Interprofessional Collaborative Competencies Attainment Survey (MacDonald et al 2009) post conference, and again online, six months later.

Our data thus far indicates that participation in vividly portrayed scenarios stimulated several areas of reflection about Interprofessional competencies. Team members enacted a variety of strategies to...
Taking an Anticipatory Approach to Handling Health and Biological Crises: Health Application of the Anticipatory Model of Crisis Management

Authors: **Juliann Scholl**, Texas Tech University  
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**Introduction/Objective:** Crisis pervades every aspect of life. Common crises include commercial product harm/recalls, industrial accidents, corporate misconduct, natural environmental disasters, and terrorism, all of which have medical and health implications on the affected communities. Medical and health-related disasters pose a particular kind of threat to the health and safety of a community. During these times, physicians, healthcare providers, and other medical personnel can play a crucial role in helping to contain a disaster, informing and aiding the public, and preventing it from occurring.

**Theoretical Analysis:** This paper overviews common types of biological and health-related crises, such as bioterrorism, epidemics, and the impacts of organizational misconduct. The Anticipatory Model of Crisis Management (AMCM; Olaniran & Williams, 2001; 2004) provides the foundation with which health and biological disasters can be anticipated and managed.

**Discussion and Implications:** The paper outlines specific strategies that can help address the most common health disasters, such as improved infrastructure and vaccination campaigns, and how the implementation of a local Crisis Communication Center can help in the design and implementation these strategies. Most importantly specific steps will be covered that enable healthcare providers and professionals to play crucial roles in these crisis management efforts.

Teaching Team Communication in Interprofessional and Monoprofessional Groups: Does it Make a Difference?

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**Introduction:** International trends in interprofessional education and curriculum development highlight the importance of preparing students with communication and teamwork skills essential for contributing effectively within today’s interprofessional healthcare teams. A pilot study explored differences between interprofessional (IP) and monoprofessional (MP) groups after a team communication seminar.

**Method:** Prelicensure healthcare students were assigned to either an IP group (medical, nursing, radiography, laboratory science and orthoptics) or an MP group (medical). Seminar participants (n=74) completed two scales from the University of the West of England Interprofessional Questionnaire (Pollard et al 2005): Communication and Teamwork [9 items; sum score range: 9 most positive to 36 most negative]) and Interprofessional Learning [9 items; sum score range: 9 most positive to 45 most negative]). Pre and post measures were made comparing attitudes to communication, teamwork and interprofessional learning. Mean scores for the IP group (n=40) and the MP group (n=34) were compared using ANOVA analysis.

**Results:** For Communication and Teamwork baseline mean scores for both groups were similar (Pre: M(IP) =18.5, M(MP) = 18.0; p = 0.82) and afterwards both showed significant (p < 0.01) positive changes (Post: M(IP) =17.2, M(MP) = 17.4).

For Interprofessional Learning, the IP group had a more positive baseline mean score (Pre: M(IP) =20.6, M(MP) = 25.8; p < 0.01). However, both groups showed significant (p < 0.01) positive changes (Post: M(IP) = 19.1, M(MP) = 23.3).

**Discussion:** Significant positive changes in mean scores for both groups towards communication, teamwork and interprofessional learning suggest that the team communication seminar had a positive impact. However, change in attitude between groups was not significantly different, meaning potential influences of the interprofessional factor were not revealed with this study. It could be assumed that qualitative methods may be more suitable.
Creating Constancy of Purpose in Healthcare: A New Direction for Healthcare Team-Patient Interaction at the Clinical Level

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Introduction: The present healthcare system is in a stable (predictable poor) state when it comes to treatment care planning strategies. Today, the system primarily divides responsibilities among healthcare professionals to achieve satisfactory patient outcomes. It is assumed that if nurses, therapists, administrators, MD’s, etc., independently fulfill their respective professional obligations (i.e., they all do their jobs) to provide the highest level of care, the patient will naturally benefit optimum outcomes. Nothing could be further from the truth. Patient-centered care, by definition, means that any treatment care planning must start with the concerns and goals of the patient upfront and not as an afterthought. What is missing is the perspective of “interaction” and direction of these disciplines working together as a system. To be effective, any system must have an aim. Similarly, a system without an aim is no system (i.e., independently pursuing self-centered goals of the discipline). Healthcare professionals (if they are really serious about achieving optimum outcomes) need to possess “constancy of purpose” when addressing patient needs and must adopt “the new philosophy” about functioning together as a team. We have observed that utilizing the Ozer Payton Nelson (OPN) Method facilitates improved interaction and is the basis for generating true patient-centered treatment planning.

Objectives:
A. Assist a patient in understanding his or her role in the treatment planning process  
B. Assist a patient in identifying a specific concern  
C. Assist a patient in transforming the specific concern into a measurable goal  
D. Generate a treatment plan that reflects the patient’s responses to OPN Method questions.

Methods: The OPN Method consisted of five 90-minute experiential training sessions conducted by the author. The Adapted Participation Method Assessment Instrument (APMAI) measured the clinicians’ ability to seek patient participation and was used for assessing the effectiveness of the instruction.

Results: Ten of the 21 criteria items on the APMAI demonstrated statistical significance (P<.05) in frequencies from pretest to post-test scoring.

Rationing Human Resources in Mental Health Care: Does Patient Gender Affect Care and Communication in Multidisciplinary Teams?

Author: **Brittin Wagner**, University of Minnesota/Veterans Health Administration

Abstract: “Collaborative care” is mental health care provided by multidisciplinary teams. It is patient-centered, or tailored to individual patients’ needs. Some patients receive care from teams composed of three or four providers while other patients’ teams become much larger. Some teams grow to include one or more highly specialized providers (such as a psychiatrist), while other teams do not. Variation in team composition is not widely documented and little is known about how teams generate and grow. This study of one large collaborative care organization documents human resource allocation across patients and uses status characteristics theory to expose key features that drive variation in patient care in a cross-section of 11,614 collaborative care teams in the United States in the Washington State Mental Health Integration Program (MHIP) during the years 2007-2010. Collaborative care uses a stepped care approach to allocate human resources (i.e. team members) to patients using evidence-based measures of mental illness severity and complexity. Controlling for severity and complexity, male patients are less likely to be referred outside of primary care and for psychiatric evaluation. Male patients get smaller teams in general. However, results indicate that providers are just as likely to consult with one another about male patients as about females. Consultation between providers may facilitate equal resource distribution (use of electronic tracking systems and weekly meetings between providers to encourage consultation about shared patients).
Hands-on Care: How Team Makeup May Affect Patient Situational Awareness in Simulation Training Environments

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Introduction: While several interactional analysis systems exist for studying verbal communication, fewer exist for exploring non-verbal channels. Both are crucial to patient-centered care. Hence, we developed the Patient Situational Awareness Coding Scheme (PSACS) for identifying intra-team and patient-focused attention, patient safety violations, and patient-directed haptic actions (touch). Here, we report findings from the latter dimension for interprofessional teams (I-Teams) and nurse-only teams (N-Teams) in two training environments.

Methods: We analyzed five simulations from Indiana University School of Nursing, where 3rd-year BSN N-Teams (2 men/8 women) treated postoperative patients; and five simulations from Ysbyty Gwynedd Hospital in Bangor, Wales, where I-Teams of 3rd-year nursing and 5-year medical students (2 men/7 women) treated patients for chest pain, asthma, sepsis, anaphylaxis, and LVF. We coded patient-directed haptic actions for: interventions, checking vitals, opening/closing the gown, and diagnostics, noting if clinicians spoke during each action (asked permission from / informed the patient of the action (“communicated”)) or acted without communicating.

Results: Our two raters had high inter-rater reliability (Krippendorf’s α: N-Teams = 0.86; I-Teams = 0.87). While it would not be appropriate to perform a statistical comparison across groups due to their differences (cultural, scenario, etc.), an arithmetic comparison of means is informative. Communication rates were as follows: across all intervention actions: N-Teams 81.3%, I-Teams 52.0%; vital actions: N-Teams 79.7%, I-Teams 53.8%; gown actions: N-Teams 53.8%, I-Teams 18.8%; diagnostic actions: N-Teams 89.3%, I-Teams 16.4%.

Discussion: Arithmetically, N-Teams communicated more frequently with patients during haptic actions than I-Teams. This may be due to professional differences, social culture, scenario objectives, confederate use, and sample size. However, the results still suggest a difference in communication dynamics. These findings warrant further research on how team makeup affects patient-centered communication, and may have implications for how clinicians are trained to interact with patients as part of interdisciplinary teams.

Health Literacy

Does Anyone Know What We Are Talking About?: A Comparative Analysis of ED Verbal Communication and Patient Knowledge

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Objectives: Many patients leave the emergency department (ED) with knowledge deficits. This study evaluated the relationship between verbal communication by ED providers and patient knowledge of discharge information.

Methods: We conducted a prospective cohort study of 30 English-speaking adult ED patients with back pain (BP) or skin lacerations (SL). Entire ED visits were audiotaped and patient knowledge of discharge information was assessed during a follow-up phone call within 24-72 hours of discharge. Verbal communication content (provider discussion) and patient knowledge were scored based on established key teaching points (TP) with a total of 15 TPs for BP and 12 TPs for SL across 4 categories (diagnosis, home care, follow-up, and return to ED instructions). Two authors scored each case independently and discussed discrepancies before providing final scores. We used descriptive statistics and logistic regression for the analyses.

Results: The final data set included 18 BP and 12 SL patients with a mean age of 42 years and 43% female. The kappa statistic for inter-coder agreement was 0.72. Both provider discussion and patient knowledge of TPs occurred with greater frequency in SL cases (71% TPs discussed, 69% known) than BP cases (58% TPs discussed, 37% known). For both diagnoses, the proportion of TPs known by patients was greater when discussed by the provider (0.82 SL, 0.61 BP) than when they were not discussed (0.26 SL, 0.20 BP). In multivariate logistic regression analysis, patient age, gender, and health literacy were not associated with knowledge of a TP; however, provider discussion of the TP was strongly associated (OR 7.3, p-value 0.000, CI 4.7-11.4).

Conclusions: Verbal communication of a TP by an ED provider significantly increases the likelihood of patient knowledge of that TP. In this sample, ED clinicians provided more complete verbal communication of discharge information for SL (procedure-oriented visit) than BP.
Medicine Package Inserts Abbreviations and Acronyms In Portuguese: Exploring How Difficult They Are For Educated People

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Introduction/objectives: Medicines package inserts (MPIs) are patient information tools that should guarantee full understanding of its content for proper and safe use of drugs.\textsuperscript{1,2} This exploratory study aimed to assess the interpretation of medicine abbreviations and acronyms (AAs) used in MPIs.

Methods: AAs were selected from biomedicine bibliographic sources, checked in MPIs and classified in 2 groups: 1) units of measure (e.g. mg/ml: milligrams per millilitre) and potencies (e.g. 10^1 (UMP\textsubscript{a}); 2) lexical (L\textsubscript{a}) (e.g. HIV: human immunodeficiency virus). AAs frequency in common written Portuguese (e.g. periodicals) was obtained from a Portuguese corpora database.\textsuperscript{3} A qualitative questionnaire, comprising open-ended and control items (N=398, 346 L\textsubscript{a}), was applied to a convenient sample of 10 university non-biomedical students. The questionnaire was divided in 2 halves and randomly assigned to participants. Data was analyzed with IBM SPSS v19, with a p<0.05.

Results: Participants completed 1910 items (plus 113 controls) and assumed not knowing the meaning of 1727 (90.4%). From the remaining items (9.6%), there was a wrong interpretation of 44 (2.3%), while control questions presented a meaningful proportion of correct answers (Chi\textsuperscript{2}=496.2, p<0.001). Greater accuracy was shown for UMP\textsubscript{a} interpretation than L\textsubscript{a} (13.9% vs. 10.3% from 52 and 346 items, respectively). All AAs were virtually absent from current written Portuguese (0 or <1 time per million of words), as well as almost all the original words. Some exceptions, such as sodium (Na) and renal failure (IR), were also not correctly interpreted by all participants.

Discussion/implications: AAs of MPIs are extremely uncommon in Portuguese. Educated individuals found AAs highly technical and difficult to interpret, with fewer issues related to units of measures. Since AAs may pose additional MPIs readability and comprehension issues, additional carefulness and regulations seem to be needed when using such expressions.

References

Patient Empowerment in Patient-Provider Consultations

Author:
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Objectives: In the Dutch healthcare system the patient is expected to be responsible for managing their healthcare. Many older patients experience difficulties in following treatment recommendations. One out of three patients who are using chronic medication appears to have problems doing this correctly. In recent years patients have asked fewer questions during consultations with their general practitioner (GP). In discussing medication, topics such as correct medication use and adherence are not frequently and consistently addressed. Elderly people appear to be most vulnerable in this respect; they are less assertive than younger patients. As a result, questions remain unanswered, patients may worry unnecessarily and may not know how to take the prescribed medication. There is a need for better healthcare provision for the elderly in order to prepare them for an active role during the consultation.

Methods: A literature search was conducted to review and identify studies about methods to improve patient participation during consultations with their GP or pharmacist. A total of over 25 articles were found.

Results: The process by which patients gain more control over decisions and actions in their care may lead to better adherence. Such empowerment is visible in consultations in the formulation of clear requests for help with health care providers. This is observed in patients expressing their concerns and doubts and in general, participating more actively in their consultation with health care providers.

Implications: Increasing patients’ participation in consultations may lead to positive health care outcomes. The result may be visible in better interaction, better use of medication and higher patient satisfaction.

Chronic Disease Management, Health Literacy and Doctor-Patient Communication: A Pilot Study

Author:
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Introduction: Low literacy individuals can have difficulty communicating with their healthcare providers (HCP), tend to be in worse health, and are less likely to make use of preventative services. Primary HCP need to tailor their approaches to the specific needs of low literacy chronic disease patients.

Objectives: 1) evaluate the feasibility of a health literacy screening test in clinical practice; 2) explore the relationship between health literacy and the quality of management of chronic disease; 3) explore how two doctor---patient communication coding schemes (RIAS and MEDICODE) can be used to study of health literacy.

Methods: Observational study design. Adult hypertensive and/or diabetic patients and family physicians (FP) were recruited from two Family Medicine clinics in Québec (Canada). Half the encounters were audiotaped. All patients completed three ques-
always. What does that result in? A movement always.”

However, over 50% reported a high confidence in understanding results showed the majority (48%) correlated to 6th-7th grade level. To date, 37 adolescents/young adults participated. REALM-Teen fortitude asking healthcare providers questions. Information from healthcare providers and over 85% reported “always understood prescription directions.

Discussion: A greater understanding of the relationship between health literacy and the quality of healthcare will help HCP tailor their approaches to the specific needs of these patients and better support the management of their chronic diseases. Two replication pilot studies are underway in Australia and in France. Comparative results will be available at the time of the conference.

A Health Literacy Assessment of Caregivers of Children with Sickle Cell Disease and Adolescents/Young Adults with Sickle Cell Disease

Author: Lisa Shook, Cincinnati Children’s Hospital Medical Center

Introduction: Sickle cell disease (SCD) is an inherited, lifelong disease affecting red blood cells. In the US, SCD affects approximately 100,000 individuals. Caregivers and individuals with SCD face many challenges, including daily management of a progressive, chronic illness with multiple complications and daily medications.

Health literacy is defined as “the ability to obtain, process and understand the basic information needed to make appropriate health decisions” and there is a demonstrated relationship between health literacy and outcomes. Currently, there are no published studies specifically about health literacy and SCD.

Methods: Caregivers of children ages newborn - 18 years old with confirmed SCD, and adolescents/young adults (14-22 years old) with SCD were recruited. Caregivers completed a demographic survey and Newest Vital Sign (NVS) health literacy test. Young adults completed the REALM-Teen and demographic survey.

Results: To date, 56 caregivers participated. Demographics showed 56% completed high school/GED; 21% completed bachelor’s degree and 14% completed master’s degree. NVS results demonstrated 93% of caregivers had “adequate” or “limited” health literacy while only 7% had a “high likelihood of limited health literacy”.

Over 95% of caregivers reported confidence in understanding information from healthcare providers and over 85% reported “always understanding prescription directions” and 90% reported being comfortable asking healthcare providers questions.

To date, 37 adolescents/young adults participated. REALM-Teen results showed the majority (48%) correlated to 6th-7th grade levels. However, over 50% reported a high confidence in understanding medical information from healthcare providers and 62% “always” understood prescription directions.

Discussion/Implications: Health literacy assessments of caregivers of children with SCD demonstrated overall “higher than average” health literacy. However, the average health literacy level of adolescents and adults with SCD is only in the 6th-7th grade level. A study limitation is sample size. Understanding health literacy levels of caregivers and adolescents/young adults with SCD is important for tailoring patient education

Transforming Care: Using Health Literacy to Embrace Authentic Partnerships with Families

Author: Lorraine Thomas, Holland Bloorview Kids Rehabilitation Hospital

Family Engagement. Family Education. Family participation and shared decision making. What does that result in? A movement towards Health Equity and Accessibility!

In 2012 Holland Bloorview Kids Rehabilitation Hospital introduced an exciting hospital wide health literacy initiative. In so doing, we gave our families the opportunity to be heard loud and clear! A health literacy committee was formed, plain language guidelines developed for staff, and a documentation review process created. The review process ensures that all our family education materials are client/family reviewed before going to print. Only when they have been approved, are the documents stamped with a special “client and family reviewed” logo!

Our health literacy initiative has become the common denominator in generating dialogue between families/clients and healthcare professionals. It brings together 3 key stakeholders essential for change: our families/clients, frontline staff and administration. It creates a synergy where staff are educated about health literacy, staff themselves become educators to support colleagues in developing plain language strategies, and families provide the last word. The creation of accessible health education materials has led to increased patient/client safety, better understanding of health information and greater compliance with professional recommendations.

As one parent says: “Participating on [the health literacy] Committee provides a forum to share the knowledge that I have gained as a parent; it allows me to voice my opinions and concerns to an organization that will listen; and it offers a way for me to make suggestions on how to improve things for Holland Bloorview clients and families.”
How to Design Health Information for Low Literate Professionals

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        Desiree Beaujean, National Institute for Public Health and the Environment

Introduction/Objectives: Landscape workers have an increased chance of tick bites and Lyme disease. Among this target group, there are many people with limited literacy skills who are not able to understand the existing educational brochures.

The objective of this study is to get more insight in how textual information can be adapted for people with limited health literacy. Earlier research shows that it is beneficial to add visual information to text. It may also be beneficial to motivate people to process the information carefully, for example by adding a motivational agent to the text: a picture and a short text of a fictitious colleague who tells the target group that the topic of the brochure is important.

To examine the effects of adding visuals and a motivational agent, a brochure on ticks and Lyme disease is developed, with the help of experts in Lyme disease and health literacy.

Methods: Data collection will be finished in April

A two-by-two between subjects design is used. Independent variables were the presence of pictograms and of a motivational agent. In a structured interview, the effects of these elements on the appreciation, comprehensibility and persuasiveness of the brochure are measured.

In total, 120 low literate landscape workers will participate in this study. To assess their level of health literacy, we use the Dutch version of the Newest Vital Sign.

Results: In progress

We will perform analyses of variance to test the effects of pictograms and a motivational agent on appreciation, comprehension and persuasiveness. Apart from that, we will analyze the qualitative results (remarks from the participants) to get more insight in how they process the brochure.

Discussion/implications: With this study we will gain more knowledge on how low literate professionals process health information and on how this information can be adapted to support them.

Patient Education

Nurses’ Perceptions about Therapeutic Patient Education

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Background: Therapeutic Patient Education (TPE) in diabetes is fundamental to improve adherence to self-disease management and its implementation in daily practice is a priority as considered by World Health Organization.

Portuguese Diabetes Association has a TPE Course for health care providers, enrolling up to 600 people/year.

Aim: Evaluate perceptions of the attending nurses in relation to TPE.

Method: 141 nurses who attended 8 courses were asked to write the meaning of TPE. A qualitative study was conducted to analyse the content of the various perceptions.

Results: All data was analysed qualitatively and categorized as:
        INFORMATION (referred by 49%) - Defined as the use of methodologies and teaching tools, orientation, training and learning to improve adherence to treatment with effective self-control.
        MOTIVATION (29%) - Set of dynamic strategies to increase motivation adapted to different disease phases, in order to improve health, lifestyle and quality of life.
        BUILDING A RELATIONSHIP (26%) - Opportunity to build and improve aid and therapeutic relationship with empathy, trust, availability, understanding, congruence, accessibility, respect, assertiveness, commitment.
        EMPOWERMENT (22%) - Getting involved and giving tools and power to the person managing his own treatment, so that he feels autonomous and responsible for disease control.
        SHARED UNDERSTANDING and NEGOTIATION (17%) - Continuous learning process with sharing of knowledge and experiences, allowing negotiation and mutual exchange.

Conclusion: TPE perceptions covered several fundamental areas of therapeutic education as: establishing effective therapeutic relationships, the role of motivation, choosing information and patient empowerment. These areas are important to optimize diabetes management and improve quality of life. Nurses’ recognition of its importance is a first step to its development and implementation. TPE courses should include this evaluation to better target its methodologies.
Can Life Coaching Improve Health Outcomes?

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Introduction/Objectives: In recent years, coaching has received special attention as a method to improve healthy lifestyle behaviours. The fact that coaching has found its way into healthcare and may provide new ways of engaging and making the patients accountable for their health justifies the need for an overview of the evidence regarding coaching interventions used in patient care, the effect of the interventions, and the quality of the studies published. On that background the major research questions in this review are as follows:

- Assess patient outcomes of life coaching interventions conducted as individual telephone coaching, individual face-to-face coaching, group coaching, or coaching combining these methods; and
- Investigate the characteristics of an effective life coaching intervention.

Methods: Interventions studies using quantitative or qualitative methods to evaluate the outcome of the life coach interventions were identified through systematic literature searches in PubMed, Embase, Psycinfo, and CINAHL. No language restriction was used. The methodologic quality was independently assessed by three of the authors using a criteria list inspired by the lists developed by Moja, Olsen, and Cherafhi-Sohi et al.

Results: Four studies were included; two of them were randomized controlled trial and met all quality criteria. The two studies investigating objective health outcomes (HbA1c) showed mixed, but promising results especially according to the patient group that usually does not benefit from intensified interventions.

Discussions/Implications: Because of the very small number of solid studies this review can only present tendencies for patient outcomes and a preliminary description of an effective life coaching intervention. To get a closer look at what is in the ‘black box,’ we suggest that the description and categorisation of the coaching methods are described more comprehensively, and that research into this area is supplemented by a more qualitative approach.

Assessment of Coping Strategies Specific to Asthma: A French Tool

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There is no tool that assess the coping of asthmatic patients in French. The objective of this study is to validate in French the Asthma Coping List (ACL).

261 patients have filled in the section « coping during asthma attack » of the ACL, and 296, the section « coping in front of daily asthma ». Furthermore, 98 patients have completed the questionnaires concerning the quality of life, depressive symptomatology, the knowledge of asthma and adherence to the treatment.

An exploratory factor analysis of the ACL has revealed 3 strategies for the asthma attack (« rational action in front of attack », « minimizing the seriousness of the attack », « reacting emotionally in attack situation») and 3 others for daily asthma (« adaptive management of asthma », « worry about asthma », « information seeking »). Cronbach’s alphas lie between .66 and .86. « Passive » coping strategies are correlated with a poor quality of life and a high level of depression. Patients using « active » strategies present a high level of knowledge and adherence to the treatment.

The psychometric properties of the ACL-F are satisfactory. It appears to be a relevant tool in the context of a patient education approach for asthmatic patients. The assessment of coping strategies for the establishment provide a more adequate educational approach.
The Use of Journaling in an Undergraduate Health Communication Course

Authors: Jacqueline Arnold, Texas Tech University
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Introduction: Health communication courses can comprise a variety of topics (e.g., patient-provider interactions, mediated health messages, cultural issues). In addition to exams, papers, and other traditional forms of assessment, journaling assignments can be effective in studying how students internalize what they are learning and make it more meaningful. Through a narrative lens, we investigate how journaling provides a more personalized and multifaceted view of a student’s understanding of and experience with health care, as well as provide an effective pedagogical tool:

Methods: A total of 96 journal entries (275 pages) were collected from an undergraduate health communication course. We will conduct an initial close reading analysis, which will allow us to look for repetition of ideas or consistencies within the data. We will then utilize open coding, which will allow us to name categories from the data. Subsequently, we will employ memo writing and analyze the categories of the codebooks in relation to the data and add more specific details to those codes. Through selective coding, we will isolate the main categories and negotiate relationships among those categories.

Results: Our narrative analysis will reveal themes that reflect patterns in learning and synthesizing health communication theories and concepts. The themes might also reveal certain health topics and patterns with which they are discussed.

Discussion: The findings will likely enable us to draw implications regarding the effectiveness of student journaling, its role in teaching health communication, and greater understanding of how narrative analysis captures students’ experience and discussions about health care.

Evaluation of Treatment Perceptions using a French Version of the BMQ Questionnaire in a Population of Patients with Severe Cardiovascular Disorder. A Monocentric Study

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Introduction/Objectives: To assess the treatment representations using the BMQ (beliefs about medicines questionnaire) specific scale (BMQ-Specific) in a French population of patients with severe cardiovascular disorder.

Methods: In a cross-sectional study of patients hospitalized in a cardiovascular rehab center in France, perceptions of medical treatment were assessed using the BMQ-Specific (including two sub-scales rating necessity and concerns). BMQ-Specific had been translated in French for the study. Anxiety and depression were evaluated using the EPICES scale (a score above 40 is related to a high level of social deprivation). Subjects were classified in 4 groups: ischemic heart disease (IHD), heart failure, lower limb vascular disorder or other cardiovascular (CV) disorder using ICD 10 and a computerized algorithm. Statistical tests were used to examine associations between BMQ-specific and HAD, EPICES and clinical variables.
Discussion/Implications: This is the first study using a French version of the BMQ-Specific scale in patients with CV disorder. No association was found between BMQ results and HAD or EPICES scales. There was a positive association between age and BMQ-cons, the older the patient, the higher the concern. However the association despite being statistically significant was clinically moderate

Development and Application of a Measure of Communication Involvement for Clinician-Patient Interaction

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Method: The CPCI is an eight (8) item scale divided into four global ratings of each participant’s behavior in the encounter. Ratings are based on observations of nonverbal vocal cues (e.g., hesitancy, warmth) and verbal acts (e.g., questions, assertions). With the aid of a codebook, trained, coders listen to encounters and rate each item as low, medium, or high. Two sets of audio data are available for the application of the coding scheme: primary care and oncology encounters.

Results: We will present initial descriptive and psychometric findings associated with scale development and application to audio recorded encounters in oncology and primary care. Lessons learned include training and coding fidelity challenges, sample differences, and evidence of inter-rater reliability and validity. We also evaluate the instrument performance (i.e., redundancy, item spread) using Rasch analysis.

Discussion: Communication involvement has been shown to facilitate deeper message processing and acceptance across communication contexts. The CPCI is the first observational measure of its kind to reflect an affective connection within clinical social interaction that is appropriate to everyday clinical work. Observational studies of involvement would provide inroads to better understanding of involvement in interactional contexts

Patient Perspectives
Smallest Worthwhile Effect of Cholesterol Lowering Strategies

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Introduction: Little is known about how patients value potential benefits and harms associated with cholesterol-lowering strategies aimed at preventing cardiovascular events (heart attack and stroke). We have defined “smallest worthwhile effect” (SWE) as “the smallest amount of patient-valued benefit that an intervention would need in order to justify associated costs, risks and other harms.”

Objective: To use benefit harm tradeoff methods to assess SWE for cholesterol-lowering strategies for primary prevention of cardiovascular events.

Methods: Benefit harm trade-off (BHTO) interview methods use evidence-based treatment scenarios to assess SWE for three strategies: 1) Statins (HMG-CoA reductase inhibiting drugs); 2) adherence to the Mediterranean diet, and 3) Garlic (Allium sativum) as a daily supplement. BHTO methods first describe expected benefits and harms in understandable language, then vary the degree of benefit portrayed for the primary outcome until the respondent changes orientation from “Yes that strategy seems worthwhile to me” to “No that strategy does not seem worthwhile,” a transition point which defines SWE for that individual. Comparing SWE values to actual degree of benefit suggested by best evidence (meta-analyses of randomized controlled trials) allows estimation of the proportion of population that would deem an intervention worthwhile.

Results: Research to date suggests a high degree of diversity among patients and between cardiovascular event prevention strategies.

Conclusions: Clinical guidelines aiming for uniform implementation of standardized practice may be misguided, as they neglect the heterogeneity of patient preferences, values, and preferred options. Health policy, including clinical guidelines, should take account of the diversity of patients’ health values as they relate to medical decision-making. Medical research and clinical practice should be guided by patients’ values.

Discussion: From June 2011 to December 2012, 188 patients completed the questionnaires. Mean Age was 71 ± 13 years with 59% male and 55% IHD. The mean value for BMQ-Specific necessity sub-scale (BMQ-nec) was 21.8 ± 4 and for BMQ-Specific concerns sub-scale (BMQ-con) was 11.2 ± 6. No association between BMQ subscales and gender, anxiety, depression or disease group was observed. BMQ-nec was not associated with age. BMQ-cons was associated with age (p<0.05), the older the patients the higher the concerns. The mean value of BMQ-cons in patients older than 80 was 3 points higher than in patients under 60.

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In Sickness and in Health: Seeking Information about Spousal End-of-Life Preferences

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The end of life (EOL) can be a costly and disempowering experience for patients and families. Therefore, communication during EOL is critical in alleviating stress and ensuring that patients receive the adequate care. In particular, spousal communication is significant during the EOL experience: many older couples are married and report their spouse as the durable power of attorney for health care or the primary source of social support. When examining spousal communication about EOL decisions, research must identify factors that motivate spouses to seek information from each other about EOL preferences, especially since fewer than half of spouses wish to be involved in EOL decision-making (Azoulay et al., 2004).

One framework that assesses the process through which individuals acquire difficult information in close relationships, such as EOL preferences is the theory of motivated information management (TMIM). Advanced by Afifi and Weiner (2004) TMIM outlines information management decisions in a three-phase process: (a) interpretation phase, (b) evaluation phase, and (c) decision phase. The three phases of information management illustrate an iterative process where assessments in the evaluation phase influence the outcome in the decision phase, as well as subsequent evaluations. In addition to understanding the likelihood of seeking information in close relationships, the theory offers adequate theoretical explanation for predicting avoidance behaviors.

By using the TMIM framework, the present study examines a spouse’s decision to seek information from his or her partner about EOL preferences. In addition to testing principles from the theory, additional factors (i.e., empathy, communicative responsiveness, marital quality, and marital satisfaction) suggested by previous research are also examined to better understand what influences the initiation or avoidance of EOL conversations between spouses. Statistical analyses report the significance of various factors that lead to information seeking and avoidance behaviors between spouses. Theoretical and practical implications are discussed.

Keywords: end-of-life, information-seeking, marital communication, medical decision-making

Understanding African-American Patients’ Refusal of Pneumococcal Vaccination

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Introduction/Objectives: The Advisory Committee on Immunization Practices recommends adults 65 and older get the pneumococcal vaccine (PnVx). However, only 46% of African Americans in the United States have been vaccinated compared to two-thirds of whites. At one urban academic practice, we found that 2.9% of white patients refused PnVx following doctor recommendation, compared to 11.4% of African Americans. To inform development of a video-based patient education message, we sought to understand this disparity by interviewing African-American patients 65 and older who had refused PnVx.

Methods: We conducted a mixed method telephone survey to assess a range of beliefs, including perceptions of susceptibility to pneumonia, perceived severity of pneumonia, and perceptions of childhood vs. adult vaccinations. Participants responded to Likert-type items ranging from 1 (strongly disagree) to 5 (strongly agree), as well as to open-ended questions.

Results: Participants’ (N=40) mean age was 73, 95% were female, 72% had at least some college education, and 35% self-reported receiving other adult vaccinations. Participants reported low personal susceptibility to pneumonia (M=2.75, sd=1.43), but recognized that pneumonia could be deadly (M=4.32, sd=0.97). Participants felt childhood vaccines were safer (M=4.24, sd=1.22) than adult vaccines (M=3.41, sd=1.40; p<0.01). Similarly, participants believed childhood vaccines were important (M=4.23, sd=1.33), yet were neutral about the importance of adult booster vaccinations (M=3.16, sd=1.48). Responses to qualitative items provided additional context for these beliefs.

Discussion/Implications: Results from our sample suggest that those who refuse PnVx understand the severity of pneumonia, yet may not perceive themselves to be susceptible to the disease. Communication strategies to improve vaccination rates among African Americans may need to include a focus on personal susceptibility. Additionally, given the differences in perceptions about childhood vs. adulthood vaccinations, the use of consistency theory in persuasive messages should be explored, focusing on the importance of vaccination across the lifespan.
An Analysis of Patients’ Perspective in the Field of Chronic Pain

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Introduction: The integration of the patient’s perspective in the medical consultation is a normative asset of person-centered healthcare. Addressing the point of view of the patient is essential for the application of shared decision-making. Yet, despite the acknowledged value of this perspective, its notion remains vague, and its definition is often left implicit. The objective of this paper is to contribute to understanding what aspects of the patient’s perspective are important to capture to facilitate agreement with doctors over a course of action.

Methods: The study is based on a corpus of 25 medical consultations in the field of chronic pain, video recorded in the Neurocenter of the Hospital of Lugano (Switzerland) and analyzed using grounded theory.

Results: In the field of chronic pain, important aspects of patients’ perspective concern the beliefs that patients hold in relation to: 1) their health conditions (what they suffer from), 2) the possible treatments (what they know about treatment) and 3) their preferences (what they would like to do). These beliefs can be consistent with the points of view of doctors, thus reinforcing the advice of doctors; or they can be inconsistent, thus opening up the stage for a difference of opinion that critically influences decision-making.

Discussion/implications: Patients’ beliefs on their health condition, treatments and preferences should be a focus of shared decision-making. Indeed, unsolved disagreement on these aspects can result in suboptimal decisions. Addressing these beliefs is, however, not trivial - especially when patients have beliefs considered to be wrong or misleading by doctors. Both doctors and patients need specific communication skills to manage disagreement. This paper concludes by identifying topics for communication trainings and educational programs targeted to the empowerment of both doctors and patients in this context.

Teaching and Evaluation

Revisiting Patient Communication Training: Introducing the AGENDA Model and Curriculum

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We have previously reported findings that physicians are frustrated by a lack of patient engagement in the medical interview. Physicians have reported issues with all phases of the medical interview. Adequate collection of information is inhibited if patients lack full health disclosure. Patients are reluctant to ask questions when they do not understand information about their medical condition or treatment plan. The inability to listening actively prevents patients from engaging completely in the interview. Patients do not participate in negotiation with physicians even when they have no intention of following medical advice, creating an obstacle to patient adherence and compliance.

For a successful physician-patient consultation patients must contribute to effective communication as well as physicians. We present the AGENDA model and curriculum as a next step in patient communication training. The AGENDA model and curriculum consist of six modules: (1) Agenda setting or communicating patient expectations early in the encounter; (2) Goals for health: helping the patient express personal objectives for particular health conditions, activities of daily living, and emotional well-being; (3) Expressing concerns, questions, and negotiations: training patients how to clarify questions, paraphrase dialogue, and when to use follow-up questions; (4) Navigating health literacy issues by identifying misunderstandings between doctor and patient about diagnoses and treatment plans; (5) Disclosing detailed information: demonstrating to patients the importance of providing detailed information and the negative consequences of incomplete disclosure concerning symptoms, conditions, and behaviors; and (6) Active types of listening: helping patients to improve their listening skills by using comprehensive, critical, empathic, and therapeutic listening during the medical encounter. We intend to present the AGENDA model, why it is important to a patient-centered encounter, and how each module fits into different phases of the medical interview.
Humanizing the Soul of Science in Graduate Medical Education through an Innovative Mindfulness in Medicine Curriculum

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Introduction/Context: Patient-centered care should be self-evident throughout graduate medical education. The factors accelerating the pace of in-patient treatment and mitigating against holistic patient care are legion. Breakdowns in health care communication, which can lead to poor health outcomes, often stem from a failure to adequately conceptualize the person under one’s care. Understanding the complex relationship patients have with self, others, and society enables holistic care. At Erlanger Health System, in conjunction with the University of Tennessee College of Medicine’s Department of Internal Medicine and Transitional Year Residency Program and medical student clerkships, a humanistic curriculum, titled “Mindfulness in Medicine” (MIM), has been created to facilitate holistic care. The MIM collaborative curriculum, designed and led by clinical chaplains, cultivates humanistic perspectives in patient care thereby “humanizing the soul of science.” The MIM curriculum expands a physicians’ concept of the person beyond just the physical problem by cultivating awareness of six core domains of humanistic functioning: Integrity, Compassion, Empathy, Respect, Altruism, and Excellence.

Description of practice innovation: The MIM curriculum educates on six core dimensions of humanistic practice for daily patient care through monthly seminars. This curriculum addresses challenges residents face throughout the program year. Each quarter focuses on one or two core humanistic domains. Each year the humanistic themes are expanded and deepened as they are revisited with variations in content or delivery. Clinical chaplains serve on in-service teams, modeling MIM themes to physicians.

Evaluation/Impact: Residents were surveyed following the first year of MIM seminars using self-report questionnaires. Results of the MIM seminars which provided valuable information on utility, needs assessment and structure will be shared.

Discussion/Implications: The implications of the innovative MIM seminars are to offer humanistic perspectives and depth to physicians and to improve both physician-to-patient communication and relationship skills. This enables sustainable holistic care and facilitates better health-outcomes.

Integration of Communications Skill Development and Other Behavioral Competencies with Simulation Training: An Innovative Curriculum from Undergraduate Years 1 to 4 at the Faculty of Medicine of the University of Montréal

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Abstract: In 2004, the Faculty of Medicine launched a multidisciplinary task force with the objective of integrating simulation training into our curriculum. It was decided that behavioral and communication skills would be a major training priority in the future program.

The group was asked to develop a faculty-inspired curriculum that leverages a model simulation center and to present a plan that would not only define the role of simulation, but also facilitate and promote interdisciplinary collaboration amongst students.

The concept of Competency Simulation-Based Learning (CSBL) was developed as a simulation-based counterpart to our traditional Problem-Based Learning (PBL) approach. It reflects a faculty vision for this paradigm.

The CSBL activities are included on a regular and recurrent basis in the curriculum of all students, at all levels of training for the entire spectrum of disciplines offered at the Faculty of Medicine, including the CPSI (Canadian Patient Safety Institute) competencies. It is currently offered to our 1000 undergraduate students on a monthly basis in our two simulation centers, the second center is 125 miles away. This curriculum establishes a model that we hope will be sustainable for the entire professional life of the students.

We believe that our systematic training approach is original in North America and reflects the basis of our vision of the “simulation paradigm”. We would like to present our educational model to the international community, so that others may benefit from this experience.

Our hope is that our approach, based on a complete integration of simulation in the various curriculums, will promote better communication, patient respect, humanistic and interprofessional practices, and will encompass far more the simple notion of patient safety that is often used to promote simulation.

Long-term Effects of Empathy Training in Surgery Residents: A One Year Follow-up Study

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Introduction: Research has shown that empathy and idealism decline during medical school and post-graduate training and among practicing physicians. High physician empathy has been linked to increased patient adherence to therapies, increased patient satisfaction, improved clinical outcomes and fewer malpractice claims. In 2010 we conducted a pilot study with otolaryngology residents at the Massachusetts Eye and Ear Infirmary (MEEI) that attempted to improve empathy and relational skills in resident physicians. This study is a one-year follow-up investigation of the retention of the knowledge, attitudes and skills acquired after empathy training.

Methods: Eight otolaryngology residents completed five assessment measures before and after empathy training, and at one year. They attended a 90-minute focus group assessing the clinical usefulness of the training, their attitudes about empathy, and the factors that they believe affect empathy.

Results: Qualitative analysis revealed that residents responded positively to the training and that they were applying the skills in their clinical practices. Quantitative analyses suggest improvement in empathy after training was maintained at one year follow-up (p=.05). Knowledge of the neurobiology and physiology of empathy remained significantly greater than before the training (p=.007). Qualitative data indicate that the training program was well-received and helpful, and follow-up focus groups provided physicians with opportunities for self-reflection and support from peers. Quantitative analysis demonstrated that improvement in self-reported empathy and objective knowledge of the neurobiology of emotions persist at one-year follow-up.

Implications: We recommend that empathy training and follow-up booster sessions become a standard component of residency training.

Resuscitating CARE in Nursing Education

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In recent Carnegie Foundation and Institute of Medicine reports, communication was found to be key to safe care of patients, improved interprofessional relationships and retention of health care practitioners for a burgeoning population. Yet the direction in nursing education has been away from teaching caring practice and towards adding greater technical skills. The focus on teaching strategic psychomotor skills in nursing education programs is critical but inadequate in preparing expert nurses. We must better integrate nursing science and caring practice in recognition that both are essential to patient care. The nurse patient relationship creates the interpersonal environment that promotes healing and provides comfort through difficult transitions.

This paper will describe how recent focus on a climate change in one university- based school of nursing has led to an opportunity to revive and revise the communication content that became embedded in the second year skills acquisition course. This curriculum change proposal in development is titled CARE (compassionate care of self and others), as we recognize the need to create resilient nurses who have capacity to nurture themselves as well as others. All of the content will be experiential with modules focused on self care, stress and coping and interpersonal, group and cross cultural communication. Introductory modules on coaching behavior change using motivational interviewing techniques will be included. The self care module will include an 8 hour experience of mindfulness and self reflection. All individual and group communication modules will focus on the practice of facilitative communication using Appreciative Inquiry. This is a strengths- based approach, grounded in positive psychology and relationship theory that promotes communication and discovery of capacity in self and others.

This curriculum change based on reviving the essence of nursing practice has the potential to be growth enhancing for our students, our patients and ourselves.
Technology and Social Media

Shaping Healthcare for Future Generations: Media Involvement in Health Management

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Media and social media play an influential role in the lives of all individuals. This is particularly true with regard to framing of women and illness. The media has depicted stories of the sharing of information and records as connected to social media outlets such as Facebook. In our exploration of the topic of medial representations of women and illness, we will explore the ties of such to social media as well as access to information. We anticipate directly connecting with individuals in the healthcare field to ascertain if there are societal norms that are forcing women into silence regarding illness and is this being perpetuated via the use of social media. We will provide insight on the role societal norms play in a woman’s ability to deal with personal issues surrounding illness, as well as the implications of communication channels and the individual’s ability to deal with personal issues. Information will be gathered and described regarding steps being taken to protect patient privacy as well as the standard operating procedures of how to handle patients who, due to the prevalence of information on the internet, have already diagnosed their illness prior to being seen by a medical doctor.

What Patients with Multiple Sclerosis Expect from a Telecommunication System Supporting their Self-Care

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Introduction/Objectives: Telecommunication systems have great potential in supporting patient self-care. However, successful implementation of such systems is predicated by integrating patient needs, values and preferences in the system design. The goal of this study was to identify these parameters in patients with multiple sclerosis (MS).

Methods: At the beginning of the study, socio-demographic information was collected. A Home Automated Telemanagement (HAT) system was demonstrated to the patients and the patients were explained how to use it. It included symptom diary, individualized exercise plan, daily progress log, structured education, and 2-way communication with provider. After the demonstration, the patients were asked to test the system without supervision. After testing the system, patients completed an attitudinal survey measuring their attitudes and acceptance of the system which was followed by a semi-structured qualitative interview aimed at identifying patient values, needs, and preferences.

Results: Among 41 patients, 63% were male and the average age was 54. On average patients had MS for 15 years; 83% responded the system was not complicated; 73% of patients would feel moderately or significantly safer knowing they are monitored by the system at home; 93% would like to use the system in the future; 85% would advise others to use it; 80% of the patients reported the system to be either good or excellent. Nearly all participants expressed interest and dedication to future use of the program, despite varying levels of previous computer experience. Major additions to the system requested by the patients included accounting for vision and dexterity limitations, individualized disease profile. tailored content, individualized symptom diary, updates on new treatments, medication reminders, comprehensive health education resources, remote televisit, verified links to health information and social media.

Discussion/implications: Addressing needs, values and preferences of MS patients can facilitate their use of telecommunication systems for self-care

Utilization of Internet Breast Cancer Information in Germany 2007 to 2012

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Objectives: As the number of people with Internet access rises, too does the number of people using the internet as a source for health information. Insight into patient use of this information may reveal indications of a shift in the patient role. This study aims to present data on the proportion of newly-diagnosed breast cancer patients treated in German breast centers from 2007 to 2012 who were using the internet for information on their disease and to look into correlations between internet utilization and socio-demographic characteristics.

Methods: One question on the utilization of the internet for breast cancer-specific health information is used in a postal survey of breast cancer patients that is conducted annually in Germany. Data from the survey are combined with data obtained by medical personnel (e.g., stage and type of treatment). Data from 23,345 patients from six annual surveys are analyzed for this paper using multilevel regression modeling to account for clustering of patients in the hospitals.

Results: Over the six-year study period, the response rate of the patients contacted remained at a steady 87% of those who consented to the survey. Disease-specific information seeking in the internet increased from 31% in 2007 to 40% in 2012. Older patients and patients with less formal education were less likely to use the internet for information on topics related to their disease. By contrast, internet use was significantly higher among privately insured patients and patients living with a partner. Native language, severity of the disease, and type of surgery were not found to be associated with internet use in the multivariable models.

Discussion: Use of the internet for health information is on the rise among breast cancer patients. The strong age- and education-related differences raise the question of how relevant information can be adequately provided to all patients.
Involving Patient Representatives in a Health Technology Assessment (HTA) Working Group on Alternative Measures to Seclusion and Restraint

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Objective: To explore working group members’ perceptions regarding the participation of three patient representatives in a working group to assess alternatives to seclusion and restraint in psychiatry and in long-term care.

Methods: We conducted semi-structured interviews with clinicians and managers of the HTA working group, exploring their perceptions of patient representatives’ participation within this working group and the factors that limited or facilitated this involvement. We also interviewed patient representatives who were involved in this working group to explore their experience. Two members of the research team used a framework based on the logic model to analyze the interviews content.

Results: We interviewed 14 members of the HTA working group, including the three patient representatives. Clinicians and managers found that patient representatives’ participation was important because they were best placed to suggest concrete solutions. Their presence led the other members to adjust the language used during the meeting and to focus the evaluation on patients’ concerns. However, they noted differences in the level of patient representatives’ participation in the discussions and in the understanding of their role. Patient representatives appreciated the friendly interactions with other group members and realised that implementing alternatives to restraint and seclusion constitute a real challenge for healthcare organisations. All respondents considered the fact that the HTA process was already underway as the main factor that limited patient representatives’ participation. Patient representatives cited the active role of the moderator, who sought their opinion on every topic, as the main facilitator.

Discussion: This study highlights a favourable attitude regarding patient representatives’ participation within a HTA working group. However, to promote this participation and enhance its impacts, some personal characteristics should be considered when selecting patient representatives, and their involvement in the HTA working group should start from the beginning, when questions and objectives are defined.

What do Service Users and their Family Members Think about Alternatives to Seclusion and Restraint in Psychiatry and in Long-term Care Facilities for the Elderly? A Qualitative Study of Patient Consultation in Health Technology Assessment

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Marie Desmartis, Quebec University Hospital Research Centre 
Mylène Tantchou Dipankui, Laval University 
Johanne Gagnon, Laval University 
Michèle St-Pierre, Laval University

Introduction/Objectives: There is growing interest in involving patients in decisions regarding health care technologies. This research project was conducted in collaboration with decision makers and Health Technology Assessment (HTA) agents in order to involve healthcare service users (and their family members) in the assessment of alternatives to seclusion and restraint in short-term psychiatric wards and long-term care facilities for the elderly.

Methods: We conducted focus groups with mental health service users and with family members of elderly people in long-term facilities from four regions of the Province of Quebec. Using a semi-structured guide, the focus groups sought participants’ views on alternatives to seclusion and restraint and on conditions that might affect their implementation. Focus groups were digitally recorded and transcribed verbatim, and we performed content analysis using NVivo 8.

Results: Participants emphasized the importance of listening and communication, both with people in short-term psychiatric care and people in residential care, for reducing the use of restraint and seclusion. Participants said that patients in psychiatric wards should receive a better welcome at the hospital and be assigned a reference person who would be involved in their case throughout the therapeutic process. Although most family members of long-term care facility residents knew little about alternatives to restraint and seclusion, they nevertheless mentioned evaluating residents’ needs, creating a stimulating home environment, and personalized occupational therapy programs as possible ways to reduce the need for restraint and seclusion.

Discussion/Implications: Participants suggested changes at a broader and more systemic level than the replacement of current measures of restraint and seclusion with alternative techniques. They favoured an approach that focused more on the person than on the techniques. This study brings in input based on care users’ real-life experience and confirms the feasibility of data collection from care users to inform HTA.
Brief Action Planning for Patient Centered Goal Setting

Presenters: Damara Gutnick, NYU Langone Medical Center
Connie Davis, University of British Columbia School of Nursing
Kathy Reims, University of Colorado Health Sciences Center

Can We Learn in the Sandbox Together? Interprofessional Case Conferences as Facilitation Tools

Presenters: Elizabeth Ross, Duke University
Anne Derouin, Duke University

Candid Conversations: Methods for Teaching Female Sexual History Taking

Presenters: Shakaib Rehman, R.J. VAMC
Monica Broome, University of Miami
Miranda Lane, University of Leads
Rob Lane, Leeds University Medical School

Communicating Using Plain Language

Presenters: Jennifer St. Clair Russell, Independent Consultant
Heather Traino, Virginia Commonwealth University

Continuity of Care: What are we Doing to Improve It?

Presenters: Suzanne Kurtz, College of Veterinary Medicine, Washington State University & University of Calgary
Tony Suchman, McARdel Ramerman Center

Diabetes, High Blood Pressure, and Stuff Like That: Applying Quantitative Sociolinguistics to Provider-Patient Talk

Presenter: Ashley Hesson, Michigan State University

Emotional Cue Workshop

Presenter: Marie Postma Nilsenova, Tilburg University

Express Rather than Impress - Discussing Individual Research Challenges among a Group of Early Career Researchers

Presenters: Marij Hillen, University of Amsterdam
Isabelle Scholl, University Medical Center Hamburg-Eppendorf
Valentina Martinelli, University of Pavia
Kimberly Gudzune, The Johns Hopkins University School of Medicine
Peter Pype, Ghent University

Improving Clinical Communication: How to Achieve and Measure Shared Decision-Making in Clinical Encounters

Presenters: Glyn Elwyn, The Dartmouth Center for Health Care Delivery Science
Stuart Grande, The Dartmouth Center for Health Care Delivery Science, Dartmouth College
Thomas Walsh, Dartmouth College

Improving the Family Meeting: An Interdisciplinary Communication Skills Training Collaboration for the ICU Setting

Presenter: Matthew Russell, Boston University School of Medicine

Improving Shared Decision-Making

Presenters: Nan Cochran, Geisel School of Medicine at Dartmouth
Calvin Chou, UCSF
Jazz and the Art of Medicine: Developing Ones Voice

Presenter: Paul Haidet, Penn State University College of Medicine

Pase, Por Favor - A Workshop in Spanish: How to Handle a Consultation with Spanish-speaking Patients

Presenters: Lucia Peralta-Munquía, Servicio Cantabro de Salud Cipriano Lamas-Meilan, Servicio Galego de Saúde Rosario Dago-Elorza, Servicio Madrileño de Salud Ana Carvajal-dela Torre, Servicio Galego de Saúde

The Physician as Pre-occupied Listener: How Well-intentioned Conversational Moves Become Major Blunders

Presenters: Jennifer Gerwing, Akershus University Hospital Karen Shklanka, University of British Columbia

Plan B, When Things Didn’t Go the Way We Were Hoping They Would

Presenters: Monica Broome, University of Miami Shakaib Rehman, Medical University of South Carolina Rob Lane, University of Leads

Professionalism in the Connected Age: Teaching Medical Students About Social Media

Presenters: Felise Milan, Albert Einstein College of Medicine Daniel Myers, Albert Einstein College of Medicine Patrick Herron, Albert Einstein College of Medicine

Reaching Your Communications Milestones Using Simulation

Presenters: Alan Rubin, University of Vermont College of Medicine Cate Nichols, UVM College of Medicine Richard Hovey, McGill University Richard Pinckney, UVM College of Medicine Tim Gilligan, Cleveland Clinic

Strengthening Relationships and Communication among Primary Care Clinicians, Specialists and Staff Across Sites of Care

Presenter: Beth Lown, Harvard Medical School

Teaching and Using an Evidence-Based Model for Patient-Centered Interviewing

Presenters: Auguste Fortin, Yale School of Medicine Robert Smith, Michigan State University Laura Freilich, Michigan State

Team and Interprofessional Communication: The Importance of Role Models

Presenter: Rebecca Riddell, University of Aberdeen

Using the Communication Assessment Tool (CAT) in Multiple Countries: An International Project to Gauge Patient Perceptions of Physician Communication

Presenter: Gregory Makoul, Saint Francis Care

Using the Relational Coordination Survey to Improve Workplace Culture

Presenter: Anthony Suchman, McARdel Ramerman Center

Using Virtual Reality Simulations and Other Technology to Enhance Clinical Skills in Motivational Interviewing, Brief Behavioral Interventions, and Improving Treatment Adherence

Presenter: Paul Grossberg, University of Wisconsin School of Medicine and Public Health
What we Aren’t Seeing: Observation and Feedback in the Clinical Setting

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Marcy Rosenbaum, University of Iowa Carver College of Medicine

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David Hatem, University of Massachusetts Medical School
Shmuel Reis, Bar Ilan University Faculty of Medicine
William Branch, Jr., Emory University
Communication and End-of-Life Issues in Pediatric Hematology/Oncology (PHO)

Presenters:
Smita Banerjee, Memorial Sloan-Kettering Cancer Center
Robin Kanarek, Kanarek Family Foundation
Julia Kearney, Memorial Sloan-Kettering Cancer Center
Eileen O'Shea, Fairfield University School of Nursing
Wilson File, UT-Southwestern

Conversation Analysis as an Approach to Studying the Medical Consultation: Illustrating Basic Principles and Applications

Presenters:
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Christopher Koenig, San Francisco Veterans Affairs Medical Center
Shuangyu Li, King's College London
Anne Marie Landmark-Dalby, Akershus University Hospital
Leah Wingard, San Francisco State University

Diverse Approaches to Overcoming Language Barriers in Medical Care

Presenters:
Lisa Diamond, Memorial Sloan-Kettering Cancer Center
Elizabeth Jacobs, University of Wisconsin School of Medicine and Public Health
Yvan Leanza, Université Laval
Gwerfyl Wyn Roberts, School of Healthcare Sciences; Bangor University
Ellen Rosenberg, McGill University, St Mary’s Hospital

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Suzanne Kurtz, College of Veterinary Medicine, Washington State University & University of Calgary
William Branch Jr, Emory University School of Medicine
Jack Pun Kwok Hung, Hong Kong Polytechnic University
Suzanne Eggins, University of Technology Sydney

The Interplay between Patients’ Emotional Cues and Concerns and Provider Responses - Four Studies Applying VR-CoDES

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Karolien Aelbrecht, Ghent University
Gerald Humphris, University of St. Andrews
Anneli Mellblom, University of Oslo
Arnstein Finset, University of Oslo

MEDICODE A Comprehensive Coding Method to Describe Content and Dialogue in Medication Discussions in Healthcare Provider-Patient Encounters: Perspectives from Medicine, Nursing and Pharmacy

Presenters:
Marie Therese Lussier, Université de Montréal
Claude Richard, Centre de santé et des services sociaux de Laval
Lisa Guirguis, University of Alberta
Roberta Goldman, Brown University
Austyn Snowden, University of the West of Scotland
Sue Latter, University of Southampton
Andrew Sibley, University of Southampton

Methodological Innovations in Coding Clinical Communication: Improving Specificity and Sensitivity for Appropriate Analysis of Particular Communication Functions

Presenters:
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Mary Catherine Beach, Johns Hopkins University School of Medicine
Ira Wilson, Brown University

Minding the Gap: Interprofessional Communication during Transitions in Patient Care

Presenters:
Mitzi Scotten, University of Kansas Medical Center
LaVerne Manos, University of Kansas School of Nursing
Patient Education: Practice and Research in French-speaking Countries - Where do We Stand?

Presenters:
Oliver Nardi, Clinique de Goussonville
Marie-Therese Lussier, Université de Montréal
Claude Richard, Centre de santé et des services sociaux de Laval
Jerome Foucaud, Institut National de Prévention et d’Éducation pour la Santé (INPES)
Myriam Deveugele, Ghent University
Lode Verreyen
Marc Van Nuland, Department of General Practice
Adriaan Visser, Rotterdam University
Suzanne Kurtz, Washington State University

Patient Participation in Medicine Consultations: Patient Expectations, Preference and Self-efficacy - Research from Canada and USA

Presenters:
Betty Chewning, University of Wisconsin-Madison
Lisa Guirguis, University of Alberta
Beth Martin, University of Wisconsin-Madison
Suzan Kucukarslan, University of Michigan

Patient’s Goals for Care: The Foundation of Shared Decision-Making

Presenters:
Howard Beckman, Finger Lakes Health Systems Agency
Melissa Wendlan, Finger Lakes Health Systems Agency
Alice Beckman, Albert Einstein College of Medicine
Eva Cohen, Tel Aviv University

Teaching and Evaluating Risk Communication as an Advanced Clinical Communication Skill

Presenters:
Paul Han, Maine Medical Center
Katherine Joekes, St George’s, University of London
Kathleen Mazor, University of Massachusetts Medical School
Glyn Elwyn, The Dartmouth Center for Health Care Delivery Science,
Adrian Edwards, Cochrane Institute for Primary Care and Public Health

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Cancer Screening, Control, and Treatment: Communication Between Patient and Provider

Presenter:
Zackary Berger, Johns Hopkins School of Medicine

Empathy: One Thing or Many?

Presenters:
Helen Riess, Massachusetts General Hospital, Harvard Medical School
Shmuel Reis, Bar Ilan University Faculty of Medicine
Judith Hall, Northeastern University

Gender and Medicine

Presenters:
Judith Hall, Northeastern University
Debra Roter, Johns Hopkins Bloomberg School of Public Health

Improving the Communication Skills of Procedure-Based Specialists

Presenter:
Kathleen Kieran, University of Iowa Hospitals and Clinics
**Introduction:**

A “Dose of Prose” is an initiative developed by faculty and students at Clemson University to research, practice, and promote bibliotherapy. This program consists of trained volunteers reading carefully selected literary works aloud to patients to promote improved communication and ultimately, better health outcomes. In addition to impacting patient satisfaction and health, the practice is intended to enhance patient-provider communication, a crucial factor in patient care.

**Background:**

Variations of bibliotherapy have occurred throughout history, as far back as Aristotle acknowledging the healing capability of literature. Organized bibliotherapy was used by Egyptians in the 13th century. Only in recent centuries has bibliotherapy been formally established, starting with attempts to treat mental illness with carefully selected readings, a practice prevalent in the 1800’s in the United States, France, England, and Italy. Massachusetts General was the first hospital in the United States to have its own library for patients, setting the standard for hospital libraries providing services for patients. During World War I, hospital library efforts were redirected towards maintaining collections for disabled veterans. (1) In Europe, a resurgence of bibliotherapy seems to be occurring as non-medical therapists have established reading pharmacies. (2) Additionally, through Britain’s “Reader’s Organization,” doctors recommend certain books to their patients and “prescribe” memberships to libraries. This bibliotherapy initiative may be one of the first formal programs in recent years in the United States, potentially rekindling the movement.

Although research on bibliotherapy is limited, it suggests that the potential benefits are significant and its risks marginal. It is associated with mental growth and development in children. Benefits for adults are substantial as well, including improved problem solving abilities and help with clinical depression, panic disorders, and obsessive-compulsive disorder. (3,4,5,6) According to Sandra P. Thomas’s work, “Bibliotherapy: New Evidence of Effectiveness,” researchers have demonstrated therapeutic benefits of reading for clients with conditions such as depression, borderline personality, and obesity. (2)

**The Program:**

Through a series of interviews of English faculty, librarians, and patients, over 120 literary works were analyzed for their therapeutic value, leading to the development of a reading list for the program. Selected readings include short stories, novel excerpts, poetry, and religious works. A volunteer reader training program was also developed, including modules on interacting with patients, infection control, HIPAA, reading styles, and components of effective communication.

Students interested in healthcare careers were particularly recruited for the program. Trained student readers worked in health care facilities such as long term care facilities, assisted living settings, hospice, and rehabilitation centers. The patients were asked to describe how they felt (using a numbered scale) before and after each reading. A majority of the patients reported overall greater sense of well-being after the reading experience. Qualitative analysis of patient and participant feedback suggests that bibliotherapy can positively impact both patients and readers.

**Reader-Patient Connections:**

Although student readers had researched the relationship between positive communication and health outcomes as well as the potential benefits of bibliotherapy, they were not as prepared for the emotional impact their presence had on patients. Students kept reactionary journals of their experiences. Many reported that institutionalized patients felt lonely and depressed. Aside from the proven relaxing effects of literary works, the patients seem to benefit from interactions with compassionate and friendly readers. One patient chose to have “Flags of our Fathers” read to her. It was especially meaningful because her husband had served in World War II and returned reluctant to discuss his experiences. She was unable to read due to disability, so she was particularly engaged with weekly readings by a student. Commentary and meaningful discussion often followed the excerpts; reading evoked something remarkable in the patient and memories came back to her as she recognized names and places from the story.

Some patients reveled in literature’s ability to allow fond memories to resurface. After being read an excerpt of “Gone with the Wind,” one individual recalled the first time she saw the movie. The reading and the conversation that followed seemed to improve her psychological state, and she shared positive feedback with her reader. By serving as readers in long-term care settings, students were exposed to the impact of age and institutionalization on the emotional and physical state of patients. The services of the student readers created positive communication and, in many cases, provided comfort and distraction for patients.

**Bibliotherapy: Continued Progress:**

This initiative has provided the foundation for the continuation of a “Dose of Prose” bibliotherapy program. The training program has been administered to over 60 student volunteers. The selected literary works have been compiled into hard copy and electronic copy compendium (doseofprose.com). The collection includes detailed information about the subject matter of each selection, its origin, and the approximate amount of time needed to read it.

The benefits of reading therapy for patients that have been established in research are myriad, but a noteworthy aspect of this project was the wide array of benefits felt by the student readers. Many reported that the experience helped their communication skills and exposed them to a type of communication that they had not yet experienced. They learned the intricacies of patient-caregiver communication, and many readers reported that this will be advantageous to future careers. Therefore, the program was mutually beneficial; students gained improved communication skills, and patients experienced the connection of human compassion and positive communication. The students and faculty involved are optimistic about the potential benefits of reading therapy as well as the application of bibliotherapy in the United States. The “Dose of Prose” initiative is a catalyst for a movement that will likely progress to other regions and settings.
The Language Abilities of Resident Physicians

Lourdes R. Guerrero, EdD, MSW, Leo S. Morales, MD, PhD and Gerardo Moreno, MD, MSHS

PURPOSE:
The Joint Commission mandates that health care systems provide culturally and linguistically appropriate care for patients. Similarly, the Accreditation Council for Graduate Medical Education (ACGME) requires that resident physicians learn to communicate effectively across cultures. The purpose of this study was to analyze residents’ self-report of fluency in a second language and level of training in the use of interpreters to assess the institution’s preparation of residents to meet mandates regarding the delivery of cross-cultural care.

METHODS:
Seven hundred and twenty two (722) surveys were analyzed from resident physicians in 62 different ACGME accredited programs. Language ability was measured with a survey question asking about comfort providing patient care in a language other than English. Knowledge of working with interpreters was measured by a survey question asking about amount of training received. Survey questions on gender, post-graduate year (PGY), specialty, and underrepresented minority (URM) status were examined using 2 and independent samples Mann-Whitney U test. Logistic regression was used to estimate the adjusted odds ratio by variable.

RESULTS:
Fifty-five percent of all of the resident physicians endorsed feeling comfortable providing patient care in a language other than English, and Spanish was the most common language (77%). Almost 20% percent of residents reported little or no training in the use of interpreters. In bivariate analysis, race-ethnicity was associated (P-value <.001) with comfort in providing patient care in a language other than English. Primary care resident physicians had a 1.67 adjusted odds ratio (95% confidence interval [CI] 1.18, 2.37; p value = 0.004) of feeling comfortable providing patient care in a language other than English compared to resident physicians from other specialties.

CONCLUSIONS:
Primary care resident physicians are more likely to report feeling comfortable in providing patient care in a language other than English. Most residents would benefit from additional education in working with interpreters.

Background:
The Joint Commission mandates that health care systems provide culturally and linguistically appropriate care for patients. Research has shown that limited English Proficient (LEP) patients have more positive medical encounters when they receive care from language concordant doctors. When there is a lack of language concordance, use of trained interpreters improves the quality of care for patients with LEP, including better understanding of medications, higher adherence to preventive care, and better ratings of doctor-patient communication. Understanding the language abilities and use of interpreters among physicians in training is an emerging national issue.

The Accreditation Council for Graduate Medical Education (ACGME) dictates the need for medical residents to learn to communicate effectively across cultures in their core competencies. The ability to communicate with LEP patients is an important component of overall competency for training programs across the country, especially for those that serve large numbers of patients with LEP. Although there are studies on medical students and practicing physicians’ language abilities, the literature examining the language fluency of physician residents is limited and often focused on the last year of training.

The purpose of this study was to analyze resident physicians’ self-report of use of a second language for patient care and to gauge their level of training in the use of interpreters to assess the institution’s preparation of residents to meet mandates regarding the delivery of cross-cultural care.

Methods: Participants and Setting
We analyzed 722 surveys from a cross-sectional web-based study conducted in 2011 of all resident physicians in 62 different ACGME accredited programs at a major academic medical center. Residents at this center provide care in different health systems that range from private hospitals to high volume safety-net hospitals with large numbers of LEP patients.

Survey Methods:
A link to the web-based survey was sent via e-mail to all residents in ACGME accredited programs in May, 2011. The survey instrument was developed by the GME office for institutional program monitoring and evaluation. Residents were informed that results from programs with less than four participants would not be sent to program directors until multi-year data was available as an additional way to ensure the confidentiality of results. The overall survey response rate was 78%. Three percent of responses regarding PGY level were missing and 18.1% were missing for identification of race-ethnicity. Of the responses with race-ethnicity identified, 14.2% were missing ratings in the use of interpreters, and 14.7% were missing for the questions related to comfort in providing patient care in a language other than English. The study was approved by the UCLA IRB.

Measures:
The main variables of interest were comfort with language ability in a language other than English and the amount of training received in using interpreters. We measured language ability with a survey question that asked: “Do you feel comfortable providing patient care in a language other than English? If so, which language?” Response options were “Yes” or “No.” We analyzed the scaled responses to the statement, “Rate the level of training you received in using interpreter services with patients who do not speak English”, with response options none, little, sufficient, much, quite a lot. Items on gender, post-graduate year (PGY), specialty, and being in a fellowship were examined.

Specialties were put into three categories: primary care, medical subspecialties, and surgical subspecialties, as Moreno, Walker, and Grumbach did in their analysis of California physicians. Race-ethnicity was also measured by self-report and included the following categories: African-American, Asian-Asian American, Latino, Mixed race-ethnicity, Native American, Non-Latino White and Other. Residents that indicated they were African-American, Latino or Native American were categorized as belonging to an underrepresented minority group (URM) in medicine.
Analysis:
We used SPSS (version 20) and Stata (version 12.1) to conduct all analyses. Frequencies and distributions of the study variables were examined first. We compared the differences of physician resident characteristics by language ability, and by ratings of how much training residents received in using interpreter services with patients who do not speak English. We then conducted cross tabulations of language ability and rating of interpreter trainings. We used χ² and independent samples Mann-Whitney U tests to determine statistical significance between categorical variables, and a p-value of < 0.05 determined statistical significance.

We conducted logistic regression analyses to determine the adjusted odds ratio of study participants reporting that they felt comfortable providing patient care in a language other than English, our measure for non-English fluency, while controlling for different resident characteristics measured. PGY level, gender, URM designation, and specialty variables were included in the model. Finally, we compared respondents and non-respondents on language fluency using χ² tests.

Results:
Table 1 summarizes the overall characteristics of the resident physicians. Fifty-five percent (n=390) of the respondents stated “Yes” to feeling comfortable providing patient care in a language other than English. Of these affirmative responses, 77.1% (n=216) stated Spanish was the language they felt comfortable providing care. Table 2 notes the resident physicians’ comfort in providing patient care in a language other than English by resident characteristics. The statistically significant differences in responses we found were by race-ethnicity, (p < 0.01) and specialty, (p < 0.001). There were no statistically significant differences among responses between residents and fellows, (p = 0.28), between PGY levels, (p = 0.135), using independent samples Mann-Whitney U test to account for the ordinal variable), or by gender, (p = 0.58).

Table 3 provides resident physician ratings of training received in using interpreter services by resident characteristics. About nineteen percent of residents received none or little training in the use of interpreters, 38.9% felt they had sufficient training, 23.4% had much and 19.3% had quite a lot. There was a statistically significant difference by training levels, (p = 0.03) and specialty, (p < 0.001). No differences were found, by race-ethnicity, (p=0.11) or by gender (p = 0.91). There was no statistically significant difference between residents’ self-reported comfort with providing care in a language other than English and their rating of the level of training received in using interpreter services (p = 0.82).

Results from the logistic regression analysis showed that primary care residents had a 1.67 adjusted odds ratio (95% confidence interval [CI] 1.18, 2.37; p value = 0.004) of feeling comfortable providing patient care in a language other than English compared to all other residents. Other variables in the model were not statistically significant (data not shown).

Discussion:
We found that half of all resident physicians at this academic medical center stated they were comfortable providing care in a language other than English. Some research has found that physician’s self-report of Spanish fluency correlates well with their patient’s report of language fluency,20 hence this finding may be an indicator of residents' provision of patient care in Spanish. Given the relatively small number residents that are likely native speakers of a non-English Language, we need to explore further when and where these residents acquired their language skills. More importantly, it is not known what level of fluency is appropriate for the provision of care under the many possible scenarios encountered in routine and non-routine clinical care.21-23

This study is the first that we are aware of that examines non-English fluency among residents across all PGY levels and specialties in a large academic medical center. We found that being a primary care resident was independently and significantly associated with higher levels of perceived comfort with providing care to patients in a language other than English. This finding is in agreement with other similar studies that focus on primary care residents,24 residents from selected specialties in their final year of training, and practicing physicians in California.19

This study also revealed that there was a significant difference in reported comfort levels in providing patient care in language other than English by PGY level. One might expect that comfort in using a commonly spoken second language (e.g., Spanish) would increase over training years as a result of continuous exposure to its use, but this is not supported by our results. Our results suggest that variation in language fluency in “a language other than English” by training year may be due to training program (as primary care residencies are only three years and PGY1-3s have higher rates of “comfort.” Another explanation may be that the difference between PGY levels may point to residents’ comfort level prior to entering their training programs (either in high school or college) or through exposure to the language during international rotations. In a recent study, medical students who participated in international medical immersion programs were able to improve their Spanish.25 Hence, it may be necessary to inquire about language exposure and training received prior to entering residency to better understand this finding.

Lastly, results from this study revealed that almost one out of five of our residents perceived they received little or no training in the use of interpreters.14 This is lower than that reported in a similar study of residents in their last year of training.26 The medical center where this study was conducted provides interpreter services for both in-patient and out-patient services, so further studies will need to look into what the barriers to use are, and how best to train our residents across PGY levels and specialties to access these services. A recent study found an association between receipt of skills training during residency and self-perceived skill in using interpreters during the last year of training.27 Physician residents are graduates of different medical schools and enter their training programs with varying experiences. Our finding may be reflective of the variation in training received during medical school or variation in services/training provided at clinical sites depending on specialty.

Our study has limitations. It was conducted at one large academic medical center, which may not be generalizable to other training sites or institutions, and is based on data from one year. We did not have data on medical school attended or other potential confounders. We used self-reports which are subject to bias. We did not measure language fluency objectively but used a subjective proxy instead; although there is evidence to support that physician self-reported data on fluency may be a good indicator of actual assessed fluency.18,28

Our study has policy implications. Many academic medical centers serve significant numbers of non-English speaking patients or are affiliated with public hospitals. This fact coupled with the belief that academic medical centers should train physicians that will provide...
high quality care to all patients in their communities, supports the premise that second language (e.g. Spanish) learning programs for medical residents should be well developed and institutionalized in some medical centers, and especially in medical centers located in metropolitan areas where there are large numbers of non-English speaking people. Graduate Medical Education programs may also need to explore further when and where their resident physicians acquired their language skills, as these might be home-acquired, from courses in high school or from immersion experiences. Finally, because of the sizeable literature that links language barriers to receipt of poor quality of care, medical centers and residency programs should consider increasing their number of qualified under-represented minorities that are fluent in a second language, incorporate fluency in more than one language as an important skill that is part of a holistic approach to recruiting and retaining residents and physicians and provide physician residents with language training opportunities.

This study was an important first step in assessing the institution’s preparation of resident physicians to meet the Joint Commission and ACGME mandates regarding the delivery of cross-cultural care. Although further study is needed to assess the actual fluency of the residents, these results provide a baseline and hope for this health delivery systems given the positive health outcomes associated with providing linguistically appropriate patient care and the need for bilingual physicians. They also present the challenge of preparing half of the resident physicians to feel comfortable in providing recommended care.

Acknowledgment:
Dr. Moreno received support from the California Endowment, and the University of California, Los Angeles, Resource Centers for Minority Aging Research Center for Health Improvement of Minority Elderly (RCMAR/CHIME) under NIH/NIA Grant P30-AG021684.

Dr. Guerrero is an evaluator for the UCLA Clinical and Translational Science Institute, NIH/NCATS/UCLA CTSI Grant # UL1TR000124.

References


### Table 1. Characteristics of resident physicians

<table>
<thead>
<tr>
<th>Resident characteristics</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total sample</strong></td>
<td>733</td>
</tr>
<tr>
<td><strong>Training level (n=747)</strong></td>
<td></td>
</tr>
<tr>
<td>PGY 1</td>
<td>199 (26.6)</td>
</tr>
<tr>
<td>PGY 2</td>
<td>194 (26.0)</td>
</tr>
<tr>
<td>PGY 3</td>
<td>173 (23.2)</td>
</tr>
<tr>
<td>PGY 4</td>
<td>93 (12.4)</td>
</tr>
<tr>
<td>PGY 5+</td>
<td>88 (11.8)</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>367 (50.8)</td>
</tr>
<tr>
<td><strong>Specialty (n=747)</strong></td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>173 (23.9)</td>
</tr>
<tr>
<td>Medical subspecialty1</td>
<td>393 (54.4)</td>
</tr>
<tr>
<td>Surgical subspecialty</td>
<td>156 (21.6)</td>
</tr>
<tr>
<td><strong>Race-Ethnicity (n=659)</strong></td>
<td></td>
</tr>
<tr>
<td>White, non-Latino</td>
<td>339 (51)</td>
</tr>
<tr>
<td>Asian</td>
<td>255 (38.3)</td>
</tr>
<tr>
<td>URM¹</td>
<td>43 (6.7)</td>
</tr>
<tr>
<td>Mixed/other</td>
<td>28 (4.2)</td>
</tr>
<tr>
<td>African American</td>
<td>16 (2.1)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>37 (5.1)</td>
</tr>
</tbody>
</table>

**Comfort in providing care in a language other than English (n=722)**

<table>
<thead>
<tr>
<th>Language</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>396 (54.8)</td>
</tr>
<tr>
<td>Spanish</td>
<td>216 (77.1)</td>
</tr>
<tr>
<td>Chinese</td>
<td>16 (5.7)</td>
</tr>
<tr>
<td>Korean</td>
<td>11 (3.9)</td>
</tr>
<tr>
<td>Other</td>
<td>25 (8.9)</td>
</tr>
</tbody>
</table>

**Training ratings in the use of interpreters (n=758)**

<table>
<thead>
<tr>
<th>Rating</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>37 (4.9)</td>
</tr>
<tr>
<td>Little</td>
<td>103 (13.6)</td>
</tr>
<tr>
<td>Sufficient</td>
<td>295 (38.9)</td>
</tr>
<tr>
<td>Much</td>
<td>177 (23.4)</td>
</tr>
<tr>
<td>Quite a lot</td>
<td>146 (19.3)</td>
</tr>
</tbody>
</table>

¹PGY = Post-graduate year

²Primary care includes: family medicine, general internal medicine and general pediatrics

³Medical subspecialties include: allergy and immunology, anesthesiology, dermatology, emergency medicine, cardiology, endocrinology, genetic medicine, gastroenterology, hematology, oncology, infectious disease, nephrology, pulmonary critical care, rheumatology, neurology, nuclear medicine, ophthalmology, pain medicine, pathology, pediatric sub-specialties, psychiatry, radiology, radiation oncology, sports medicine

⁴Surgical subspecialties include: head and neck surgery, obstetrics and gynecology, orthopedic surgery, plastic surgery, general surgery, thoracic surgery, and urology

⁵URM: African-American, Hispanic/Latino, and Native American

### Table 2. Resident rating in providing patient care in a language other than English by resident characteristics

<table>
<thead>
<tr>
<th>Resident characteristic</th>
<th>Comfort in providing patient care in a language other than English</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (%)</td>
<td>No (%)</td>
</tr>
<tr>
<td><strong>Training level (n=722)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PGY 1</td>
<td>111</td>
<td>74</td>
</tr>
<tr>
<td>PGY 2</td>
<td>106</td>
<td>84</td>
</tr>
<tr>
<td>PGY 3</td>
<td>92</td>
<td>76</td>
</tr>
<tr>
<td>PGY 4</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>PGY 5+</td>
<td>43</td>
<td>41</td>
</tr>
<tr>
<td>Fellow (n=190)</td>
<td>110</td>
<td>80</td>
</tr>
<tr>
<td><strong>Gender (n=722)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>225</td>
<td>162</td>
</tr>
<tr>
<td>Male</td>
<td>230</td>
<td>154</td>
</tr>
<tr>
<td><strong>Specialty (n=722)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>114</td>
<td>59</td>
</tr>
<tr>
<td>Medical subspecialty¹</td>
<td>114</td>
<td>111</td>
</tr>
<tr>
<td>Surgical subspecialty¹</td>
<td>96</td>
<td>66</td>
</tr>
<tr>
<td><strong>Race-Ethnicity (n=659)</strong></td>
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<tr>
<td>White, non-Latino</td>
<td>137</td>
<td>139</td>
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<tr>
<td>Asian</td>
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<td>109</td>
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<tr>
<td>URM¹</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>Mixed/other</td>
<td>11</td>
<td>8</td>
</tr>
</tbody>
</table>

### Table 3. Resident physician ratings of training received in using interpreter services with patients who do not speak English by resident characteristics

<table>
<thead>
<tr>
<th>Resident characteristic</th>
<th>Training received in using interpreter services</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None (%)</td>
<td>Little (%)</td>
</tr>
<tr>
<td><strong>Training level (n=745)</strong></td>
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<td></td>
</tr>
<tr>
<td>PGY 1</td>
<td>17 (8.5)</td>
<td>37 (18.6)</td>
</tr>
<tr>
<td>PGY 2</td>
<td>9 (4.6)</td>
<td>24 (12.4)</td>
</tr>
<tr>
<td>PGY 3</td>
<td>6 (3.4)</td>
<td>21 (12.1)</td>
</tr>
<tr>
<td>PGY 4</td>
<td>2 (1.2)</td>
<td>34 (19.3)</td>
</tr>
<tr>
<td>PGY 5+</td>
<td>2 (1.2)</td>
<td>6 (3.8)</td>
</tr>
<tr>
<td>Fellow (n=195)</td>
<td>11 (5.6)</td>
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<tr>
<td><strong>Gender (n=722)</strong></td>
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</tr>
<tr>
<td>Female</td>
<td>21 (5.3)</td>
<td>45 (11.5)</td>
</tr>
<tr>
<td>Male</td>
<td>16 (4.5)</td>
<td>39 (10.9)</td>
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<tr>
<td><strong>Specialty (n=280)</strong></td>
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<tr>
<td>Primary care</td>
<td>4 (2.1)</td>
<td>19 (10.9)</td>
</tr>
<tr>
<td>Medical subspecialty¹</td>
<td>29 (7.1)</td>
<td>68 (18.6)</td>
</tr>
<tr>
<td>Surgical subspecialty¹</td>
<td>3 (1.9)</td>
<td>8 (2.3)</td>
</tr>
<tr>
<td><strong>Race-Ethnicity (n=653)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, non-Latino</td>
<td>16 (4.7)</td>
<td>44 (13.1)</td>
</tr>
<tr>
<td>Asian</td>
<td>11 (3.3)</td>
<td>35 (13.8)</td>
</tr>
<tr>
<td>URM¹</td>
<td>0</td>
<td>7 (1.7)</td>
</tr>
<tr>
<td>Mixed/other</td>
<td>3 (2.0)</td>
<td>2 (1.0)</td>
</tr>
</tbody>
</table>

¹PGY = Post-graduate year

²Primary care includes: family medicine, general internal medicine and general pediatrics

³Medical subspecialties include: allergy and immunology, anesthesiology, dermatology, emergency medicine, cardiology, endocrinology, genetic medicine, gastroenterology, hematology, oncology, infectious disease, nephrology, pulmonary critical care, rheumatology, neurology, nuclear medicine, ophthalmology, pain medicine, pathology, pediatric sub-specialties, psychiatry, radiology, radiation oncology, sports medicine

⁴Surgical subspecialties include: head and neck surgery, obstetrics and gynecology, orthopedic surgery, plastic surgery, general surgery, thoracic surgery, and urology

⁵URM: African-American, Hispanic/Latino, and Native American

⁶Includes both Mandarin and Cantonese

Other languages include: Arabic, Armenian, Czech, Farsi, German, Hebrew, Hindi, Italian, Portuguese, Romanian, Russian
A Different Type of Medical Tourism
Rachel Dunlap, BA, MS, MD candidate 2016

We arrived at the Hospital Universitario Virgen del Rocio emergency room by taxi. At four a.m., half of the lights in the blue-walled corridor were off and the reception desk was vacant. My parents peered down empty hallways while my boyfriend, Andrew, held his side and grimaced. After a week of tapas in Madrid and castle ruins in Granada, his appendix had waited for our arrival in Seville to launch its rebellion.

A hospital employee emerged from an unmarked door, looking unsurprised to see four rumpled Americans stranded by the entrance. “Buenas noches,” he started, and then offered a string of useful information that we did not understand. “Lo siento, no hablo Español,” I quickly ran out of words, my college French rendered useless.

Undeterred, the man led us into an office where Andrew’s passport was copied and his insurance card was glanced over. He received an ID bracelet and directions to sit in a dimly lit waiting room. We headed toward a bank of plastic chairs and settled in.

Fourteen hours later, my parents and I were still in our seats, while Andrew and his appendix rested in a large room filled with patients down the hall. The day had been composed of long stretches of waiting punctuated with blood tests, an ultrasound, and a diagnosis of appendicitis. We had landed at the hospital on a Sunday, and there were no translators to be found. Events that would have made sense to an American were no longer predictable.

That is not to say the day was without humor: Andrew popped a thermometer into his mouth before the nurse, horrified, grabbed it and tucked it into his armpit. Next, a cheerful woman introduced herself and, before we knew what was happening, abruptly shaved his torso.

“We will operate if there is time,” the young, kind resident said in English, offering a reassuring smile before disappearing.

“You have worries?” a different doctor asked, thrusting a five-page consent form written in Spanish at Andrew.

“No worries!” he signed with gusto.

Later, he was asked for his weight, with the follow-up question, “And do you know what that is in kilograms?”

And yet, despite trying to stay light-hearted, it was difficult not to grow desperate as the sun began to set. It was hard not to feel quite, for lack of a better descriptor, American. Details that should have been inconsequential -- cigarette smoke in the stairwells, a missing toilet seat in the women’s bathroom, broken waiting room chairs, the long wait times - seemed disproportionately dire.

“What happens if they just don’t operate on him?” I asked my mother, a woman who had organized our trip on a color-coded spreadsheet and is full of back-up plans. “I have no idea,” she replied.

Throughout my first year of medical school, our instructors emphasized the significance of communication. We discussed the importance of tone, body language, and avoiding overwhelming patients with medical terminology. We even attended a workshop where we traveled to a farm to interact with horses and worked on creating a calm and peaceful energy, like one might with an anxious patient. Communication, we were told, is crucial for effective healthcare.

On the other side of the Atlantic and on the patient side of the medical system, this point felt truly important. It did not matter that we were in a renowned hospital, an institution that had conducted Spain’s second face transplant. It was irrelevant that Andrew needed a routine laparoscopic surgery. We even had a physician with us, my father, which should have been comforting. Yet, because I didn’t know what was happening, when or if Andrew would receive his operation and its outcome, worst-case scenarios crept into my imagination: a rupture, an infection, a hemorrhage. The unknown in a hospital, I learned, can be very frightening.

From anatomy to biochemistry, there are so many lessons I hope (perhaps futilely) to retain as I eventually begin to practice medicine. The unique discomfort I felt at the Hospital Universitario Virgin del Rocio is among them. Obstacles to communication range from language differences and dense medical vocabulary, to low literacy levels and overwhelming circumstances that prevent patients from absorbing information. Regardless of their origins, I learned firsthand how these barriers impact patient-doctor communication and limit the patient’s sense of order and control. Whether it is through a translator, an extra conversation, or even a diagram, I hope to remember to address these gaps in my future practice.

Fortunately, and predictably, Andrew’s appendix was removed that evening. His surgeons were excellent and there were no complications. With nothing more than Paracetamol, Augmentin, and some tuna cubes from the food service, he recovered quickly. Two days later we were on the train to Barcelona, joking about how there will always be a little piece of him left in Seville. He has yet to receive a bill.
Communicating about psychosocial cancer care facilities: balancing between research and health care policy.

The case of the effectiveness of Dutch psycho-social interventions for oncology patients and their relatives

Marieke Wildenbeest, MSC¹, Adriaan Visser, PhD²

Introduction
In the Netherlands, oncology patients and their relatives have several possibilities to receive professional psycho-social support, in most cases free of charge. These care facilities are not only part of the oncology care in hospitals, but offered by independent institutes throughout the whole country. This is different from the psycho-oncology care in the USA, and may be seen as a luxury consequence of the social and solidarity aspects of the Dutch health care system. In this article we reflect on this situation from the point of view of the effectiveness of psycho-social interventions for oncology patients.

Effectiveness vs. costs
Aging and the earlier and better treatment options lead to a growing number of people with cancer, who are also living longer as survivors. The consequence is that an increasing number of people with cancer and their proxies are using psychosocial care facilities e.g. by (self) reference to psychologists, psychiatrists and psychosocial oncology centres. However, the government intends to reduce the costs of the often still free of charge therapies. They asked an advice of the Dutch Board of Health Insurance (CVZ). In a study we reviewed the existent reimbursement of psychosocial support for people with cancer according to the effectiveness principles of the CVZ. These principles are that the care should meet the criteria of ‘Scientific and Clinical Standards’ and the principles of Evidence Based Medicine.

Methods
The study is a literature research in the Cochrane Library, PubMed and sEURch for (systematic) reviews and meta-analyses. The topic was: existing evidence regarding the effectiveness of the several therapies which are often applied in the Dutch psychosocial cancer care. The studied therapies are: individual psychotherapy, group counseling, haptotherapy, art therapy and mindfulness-based stress reduction courses. The results were compared with data in the Dutch psycho oncology literature about the evaluation of the offered psychosocial care at the Dutch Institutes of Psycho-oncology.

Results
The literature review raised 11 studies of the Evidence Based Medicine (EBM) level A1 and 2 studies of EBM level B. Almost all reviews showed significant improvements in several outcome measures: anxiety, depression, quality of life, fatigue, and social well-being. However, the reviews indicated that there were only few random control trials (RCTs), and they recommend additional RCT research in the field of psychosocial cancer to improve the strength of the outcomes of these studies.

Concerning the Netherlands, only a few studies were found with significant results on improving the anxiety, depression, quality of life, fatigue, and social well-being at particular Dutch institutes. The effectiveness research done by the institutions itself does not meet the mentioned requirements of the Dutch Board of Health Insurance.

Conclusion
The psychosocial therapies offered at the Dutch institutes of psychosocial cancer care mostly do not comply with the international effectiveness requirements and the requirements for reimbursement of the Dutch Board of Health Insurance. Striving for evidence for the effectiveness of Dutch psychosocial cancer care, the institutes should adapt their current not shown effective protocols for psychosocial cancer care. Alternatively, the Dutch psychosocial cancer care institutes need to perform their own effectiveness studies, meeting the criteria of RCTs.

Implications
Health care costs have increased enormously in the Netherlands over the past decades. To make the health care costs more manageable, the CVZ did introduce a more stringent package management, also for the psychosocial oncology. Because effectiveness of care is part of the criteria of insured care, it is important to prove the effectiveness of psychosocial support for people with cancer.

The goal of the literature review was to obtain an overview on the plausibility that individual psychotherapy, group counseling, haptotherapy, art therapy and mindfulness-based stress reduction courses. Interventions are effective. The literature research determines what is known about the effectiveness of these five therapies. It is clear from the literature we found that the therapies are not proven effective in comparison with the not well defined therapies provided by Dutch institutions. The question is if these institutions itself does to have to demonstrate the effectiveness of their therapies. If they are not able to do that, the consequence of a firm point of view of the Dutch Board of Health Insurance may be the reduction of the number of therapies that are free of charge for cancer patients and their relatives.

References
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On April 15, 2013, two brothers bombed the Boston Marathon, killing three and wounding hundreds. In this issue, we reprint a piece written by Beth Rider in the aftermath of the September 11 bombings, noting the important connection between external events and healthcare communication.

It’s Because They Didn’t Know Our Names

Elizabeth A. Rider, MSW, MD, FAACH

“I know why it happened,” said 5-year-old Hannah, explaining the terrorist attacks. “It’s because they didn’t know our names.”

Since the terrorist attacks, I find myself focusing more on the hidden agenda and working in the metaphors of children’s communication, seeking to understand their perceptions about the terrorist attacks as well as my own.

A DAY IN PEDIATRIC PRACTICE IN THE TIME OF TERRORISM

Elena, 16 years old and the first patient of the day, presents with “pounding heartbeat.” As we talk, it becomes clear that her palpitations likely express her anxiety about the terrorist attacks. Her worried father thinks her palpitations occurred because she didn’t eat breakfast. As we talk about the feelings around the attacks, she visibly relaxes and her father listens intently. The cardiac workup is negative and the palpitations do not recur.

After a 3-year-old well-child visit, Sarah’s mother shares that Sarah has seemed anxious and worried since the terrorist attacks. We talk further. I kneel down to Sarah’s eye level and tell her “your mommy is safe, your daddy is safe, and you are safe.” She looks at me with big, attentive eyes and I know I have connected. With solemn seriousness, she slowly pulls her lollipop out of her mouth and says, with great emphasis, “And my kitty cat.”

“Yes, your kitty cat is safe too.”

Caroline is next. She lives with her mother; her father is not involved. Since the terrorist attacks, stomachaches plague her, yet only when she is at her elementary school away from her mother. Further exploration reveals her perception that many planes crashed into tall buildings (as she saw repeatedly on television), and she worries that her mother’s workplace, four stories tall, will be hit next. She also worries that a plane will crash into her school. We discuss her worries, her mother’s and her safety, the safety of her school, and how far away New York City is. We work out a way for her to contact her mother from school when she is worried. Several weeks later, her mother reports that Caroline’s stomachaches are mostly gone and she is less anxious.

My next patient is a mother who moved to the United States several years ago with her husband and two small children. She shares that she and her family left their home in Colombia because of the terrorism there and came to the United States for safe refuge. We talk about the irony. A mother from New Zealand tells me her family has encouraged her to return home where it is safe.

I then see an Arab American father and his 5-year-old daughter. She has a viral rash. After her father asks many questions about chickenpox, I ask if he is concerned about anything else. He asks if she has smallpox. I provide reassurance and information, and he expresses his gratitude and relief.

I schedule a baby for an MRI examination, and his mother cancels the hard to come by appointment. She confesses that she fears that the hospital might be bombed while she is there with him. We talk at length about her fears, and she does finally bring her son for his MRI.

The evening on call brings telephone calls from patients seeking Cipro and the smallpox vaccine and asking where to buy gas masks. A mother of two children with allergic rashes worries that they may have anthrax.

LISTENING FOR THE UNSPOKEN

I realize that my patients look to me for reassurance and answers about the terrorist attacks and their safety. One mother comments, “You’re so smart. I thought you would know what to do.” I have few answers, but I do know that we must move on and live our lives, although with increased vigilance and care for each other and our communities. I hold on to my hope that we all will survive and grow with time. I must nurture this hope for my patients. So I work to hear my patients’ anxiety, label it, empathize, and help them talk about their feelings so they can decrease their worry symptoms and move on with their lives.

The terrorist attacks give me renewed perspective, not only with my own family but also in my focus with patients. I remember how important it is to learn about our patients beyond their medical ills, to listen to their feelings and their metaphors, to hear the hidden agenda, and remain patient centered. We must learn their names.

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ANIMALS MAKE US HUMAN: Creating the best life for Animals


Available in hardcover, paperback, audio book and Kindle edition

Temple Grandin believes that she suffers from a form of autism, that has hampered her in relating to other human beings but helped her understand better the feelings and behaviors of other animals, I think she can and does help us relate to each other, even if we are all humans. I first came across Grandin’s writings when prompted by Oliver Sacks who was interested in the strange phenomenon of Empathy and what it might be to empathize with piglets more than with human children. Here are a few of Grandin’s thoughts on piglets:

Pigs have lively, active minds, and they need to live in an enriched environment that lets them stimulate their SEEKING emotion. In my research, the piglets raised in a barren plastic pen were much more hyper than piglets raised on straw. … Pigs are obsessed with straw. When I threw a few flakes of wheat straw into my pen of piglets, they rooted in it at a furious pace. After the straw had been chewed up into tiny short pieces, they lost interest. The chewed up straw was now boring and no longer novel.

Grandin thinks animals have key feelings: SEEKING, FEAR, PLAY and RAGE. My animals are dogs and dogs do a lot of seeking. They are quite curious and playful. I can toss a rag doll and expect that my dog will go find it, play with it, and then bring it back to me so I can toss it again. Grandin tells me about positive reinforcement and negative reinforcement. Much that has been written about training dogs emphasizes negative reinforcement. When the dog doesn’t heel, I am to give a little tug on the leash, perhaps stand still until the dog’s frustration with no forward progress convinces him to come back to me. It seemed a reasonable ploy. But how much better if I could encourage the dog to come back to me by a treat, something positive! I’m working on it now.

Of course, Grandin doesn’t think that her observations only hold for domestic animals. Yes, chickens like to hide in a little box when they plan to lay an egg. Yes, cattle being led up to slaughter do better on a curved ramp than on a straight one. Yes, the chickens are responding to their fear emotion and the cattle perhaps to their curiosity and seeking emotion. But people are curious too.

And here are Grandin’s central ideas: “Emotions drive behavior. Emotions come first.” And “The more freedom you give an animal to act naturally, the better, because normal behaviors evolved to satisfy the core emotions.”

Grandin has many books, many articles. We all could gain from them. We would be more happy, perhaps more human. And our piglets, our cattle, and our pet dogs and cats will find their lives enriched. Even our patients might do better!

THANK YOU FOR LISTENING: Gain Influence and Improve Relationships

Marc Wong
self-published, paper, 2012
Available in paperback and Kindle edition

Marc Wong says:

Listening is the art and practice of putting someone else’s speaking, thinking and feeling needs ahead of your own.

Wong has written a neat little primer on listening that we all could enjoy reading. But I found it pretty familiar, almost too much like other books I’ve read and even written, until I got to the section on women’s shoes. That woke me up.

We’re planning an October trip to Prague and Budapest. Asked what she was looking forward to, my dear wife answered, ‘Shopping.” For what? “Shoes, of course.” Oh yes, of course. Why else would anyone go to Europe? I expect that when suitcase packing time comes, I will have two pairs of shoes and Connie will have six. When we amble past a Ferragamo, she will stop and I will ask, “What now? You already have a suitcase full of shoes.” I will get a dirty look. Wong says I have to make a real effort to understand her position and her problems:

Things are complicated. The right pair of shoes can make or break an entire outfit. So you have to be on a constant lookout for new shoes. You travel with different shoes so you can dress appropriately for all occasions. When it works, it’s as if you put together an artistic creation. …On the other hand, you feel self-conscious when you have to wear shoes that don’t match the rest of your outfit and vow to never again let that happen. …Having more shoes in your closet is like having more colors on your palette. It gives you the freedom to mix and match and to be creative.

You simply cannot have too many shoes. To help us guys empathize with the women in our lives and with their shoe shopping, Wong suggests we consider our own enjoyment of tool-shopping in a good hardware store. You simply can’t have too many tools, right? I just bought a new chargeable battery-powered hand drill. I absolutely
needed it, though, to be truthful, I haven’t yet taken it out of its box. But you just can’t have too many tools.

OK, Thank You for Listening may be familiar to readers of The Medical Encounter. But it is written with charm, with some lovely examples, and Oh, those shoes! I loved it.

WHAT DOCTORS FEEL: How Emotions Affect the Practice of Medicine

Danielle Ofri, MD.

Available in hardcover, paperback, audio book and Kindle edition

I would ask those of you who are at least 50 years old whether you heard, anytime in medical school or residence training, that you would experience strong emotions in your own medical career. Did someone tell you not only that you would have to work with frightened, angry, sad patients who suffered and died, but also with your own strong emotions, many of them painful? Well, that conversation never occurred in my education. I spent many years of medical education at good medical centers (Stanford, University of Chicago, and University of Colorado) and had many fine and thoughtful instructors, some of whom were actually practicing doctors. We talked about immunology and oncology and radiological methods, but not of anger, fear, and sadness. Danielle Ofri remedies that lack.

This fine writer gives us a wonderful book, one I would recommend for any clinician or anyone who is related to one. She tells us about the feelings we will definitely experience: anger, fear, embarrassment, guilt, shame, disillusionment, sadness, loss, grief, frustration, boredom, and others. She presents thoughtful analyses of all and often tells the experiences her colleagues have described and those she herself experienced. Every anecdote rings true and reminds me of times in my own life, experiences and feelings that perhaps I left almost untouched for years and even now benefit from thinking about them.

One example: Ofri describes a patient she worked with intensively who then turned up dead at another hospital. Ofri was called and told of his death and asked if he had any living relatives. Ofri didn’t know. “Didn’t you ever ask him?” the social worker said. Ofri experienced a terrific combination of embarrassment, guilt, and grief. Of the three, the hardest to put down was the grief. She says,

After staring at Mr. Edwards’s name on the list for what seemed an eternity, I walked numbly back to my office and stood in front of the door, unable to open it. A patient was waiting inside - alive and kicking but saddled with a medley of chronic ailments, one of which would surely do him in eventually. I didn’t know if I could do it again: invest and then grieve.

I retired from practice five years ago. Lots of reasons: paperwork, non-responsive colleagues, insurance companies, ... but chief amongst the feelings was the accumulation of episodes of grieving. Too many deaths and I wanted it to stop. Might I have had it easier if I had sought out someone or a group to share the grieving with? Maybe. But even with my own writing and conversing about it, sadness and grief remained a companion in the practice of medicine. One of my poems on retirement was “Nobody dies on my shift today.” I was grateful for that change.

Ofri writes about empathy and “the factors that ambush the empathy that students enter medical school with.” She talks about Osler’s famous essay “Aequanimitas” and the optimal emotional distance between doctor and patient. She remembers her professors thirty or forty years ago, older white men in starched white coats who “Simply treated every patient with respect, and strove to learn as much as possible about each one.” She recalls rounding with them at Bellevue, thinking them out of place in a ward filled with Hispanics, Asians, and blacks. But now she realizes that treating the patients with “old-school respect,” exhibiting genuine curiosity about their lives, led the patients to respond wholeheartedly.” She says:

The very act of taking a patient and her story seriously, of being truly interested in knowing who the patient is and what her life is like and how she came to be ill and what her resources for dealing with illness were, is the basis of empathy. ... So teaching empathy to medical students is a task of the supervising faculty’s, one they fulfill every day on rounds on the wards.

This is a very important and very fine book. We must share with our students, at every level, what it really means to be a clinician, to work with patients, to join with them. We have to meet our own feelings and be able to talk about them. Our students are entering a world of suffering; they go in suffering’s way. We have to do better preparing them for the experience.

Grief tugs insistently at doctors. We form relationships—like all humans colliding in this world - but our partners in these relationships die off with a regularity that isn’t common elsewhere. A thread of sorrow weaves through the daily life of medicine, even during the mundane and pedestrian encounters. It is disease, after all, that we are dealing with, not misdemeanors, philosophies, or building foundations. ...