

2 COMET

1 Boston
June 28th-30th

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8th Interdisciplinary Conference on
Communication, Medicine, and Ethics



Boston University School of Public Health
Department of Health Policy & Management

 College of Health & Rehabilitation Sciences: Sargent College





COMET CONFERENCE

The Conference on Communication, Medicine and Ethics (COMET) evolved in 2003 at Cardiff (UK) to bring together communication researchers from different disciplinary backgrounds, ranging from healthcare specialties to the human and social sciences. Following the overwhelming success of the first conference (attended by more than 200 participants from 20 countries), which was hosted by the Health Communication Research Centre at Cardiff University, COMET has now established itself as an annual interdisciplinary, international event. Grounded in a problem-oriented approach, COMET places special emphasis on the dissemination of high quality research in discourse/communication and practical ethics which is directly relevant to healthcare practitioners. COMET is now closely linked with the new journal Communication & Medicine (Mouton de Gruyter, Berlin), with a view to bringing influential research to a wider readership.

COMET SOCIETY

The COMET Society is aimed at strengthening and sustaining a multidisciplinary network of researchers, educators, healthcare professionals and research students. Its objective is to facilitate the exchange of ideas and the promotion of the study of communication-oriented research and development within the broad fields of healthcare. (www.cometsociety.com)

BOSTON UNIVERSITY SCHOOL OF PUBLIC HEALTH

Stressing the practical application of an exceptional education to the complex challenges facing public health professionals today, BUSPH has grown tremendously in recent years with more than 4,000 alumni, 140 full-time faculty, and students from over 40 countries. In keeping with the School's service-oriented philosophy, each department combines research and academics with a practicum requirement, resulting in a rigorous, well-rounded curriculum enhanced by work experience in a public health environment. Through longstanding collaborations with such institutions as the Massachusetts Department of Public Health, the Boston Public Health Commission, and the Veterans Affairs Administration; and international alliances with the Red Cross, the Peace Corps, and foreign governments, our students, faculty, and alumni draw on their own diverse backgrounds to carry out the School's mission in a variety of settings.

COLLEGE OF HEALTH AND REHABILITATION SCIENCES: SARGENT COLLEGE

Boston University College of Health and Rehabilitation Sciences: Sargent College is an institution of higher education, research and clinical centers whose leading academic programs prepare dynamic health professionals to best serve the healthcare needs of society. Our professional graduate programs are ranked among the top 15 percent in the country by U.S. News & World Report. Our faculty includes nationally and internationally recognized scholars, researchers, and practitioners. We are a world-class research institution, securing more than \$9 million in outside funding, among the highest at Boston University. With more than 14,000 alumni in over 53 countries, over 1,200 current students and more than 1,400 affiliated clinical sites throughout the world, Sargent College is a leader in providing the best education for future health professionals.

CENTER FOR HEALTH QUALITY, OUTCOMES AND ECONOMIC RESEARCH

Committed to leadership in understanding and improving the delivery, quality, and value of health care for veterans and the nation through excellence in research and education, The Center for Health Quality, Outcomes and Economic Research (CHQOER) is one of the 14 Centers of Excellence within the United States Veterans Administration Health Services Research and Development Program. The Center's three research priority areas are: patient-centered care, medication effectiveness, and patient safety. Across these domains, researchers develop innovative methodologies and models of care to provide the most effective, efficient and appropriate care to

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GENERAL INFORMATION

June 28th 2010

Dear Colleagues,

Welcome to COMET 2010 in Boston, Massachusetts USA. This letter serves as a way to keep housekeeping matters during sessions to a minimum. Please read through the letter at your earliest convenience.

Finding Your Way Around

All official conference activities will take place at the School of Management at Boston University. (See page 10 of this booklet for an area map). Activities will take place on four floors of this building: the main floor atrium and auditorium, the 4th floor's Executive Leadership Center, the 2nd floor's rooms 208 and 222, and finally the Trustees Center Ballroom on the 9th floor. Signs will be placed in key locations during the conference program to help guide you to the various activities. A Starbucks is located on the 2nd floor; it accepts cash only.

Help Desk and Notice Boards

The help desk is located on the 4th floor Executive Leadership Center just to the left of the elevator bank. A notice board is displayed at the desk to alert attendees to program changes and personal announcements.

Program Update

It is possible that after we went into press, there may have been some last minute changes and cancellations. We will make necessary announcements during plenary sessions and on the notice board at the help desk.

Technical Support for All Presenters

All presentation rooms are equipped with a computer, projector and screen. If you sent your presentation file ahead of time we have also saved it to the desktop of the computer in your indicated presentation room. Please carry a back up copy of your presentation on a flash drive.

Poster Presentations

The poster session will take place on Tuesday afternoon from 3:00-4:15 in the atrium of the main floor. If you are presenting a poster please check in at the help desk during Tuesday's breakfast or morning break to mount your poster to the display board. You will need to be at your poster for the duration of the session.

Works in Progress for Roundtable Discussion

This is a new format at COMET this year. Round tables offer an opportunity for less formal, yet more in-depth exchange of information. Discussions of work-in-progress provide conference participants opportunities to meet, discuss, and to expand their networks around conceptual, methodological, professional or policy concerns related to their areas of inquiry. Works in progress roundtable discussions are particularly valuable for those who are developing new ideas who would like to explore these ideas or issues with colleagues who have similar interests.

Format:

- Roundtable sessions will be held in the dining room set with round tables that seat 10 – 12 people each.
- The entire roundtable session will last 90 minutes, allowing 15 minute presentations with the remaining time for discussion.
- A general topic has been identified for each table, there will be three to four presenters at each table, each presenter will present their topic for 15 minutes, a table moderator will coordinate and facilitate table discussions.
- AV resources will not be available. You may choose to bring handouts for 10 people.
- To facilitate focused interdisciplinary discussion roundtable abstracts are grouped according to the following topics:
 - Eliciting and Understanding the Perspectives of Children
 - Teaching Communication to Health Care Professionals: Identity Construction
 - Telemedicine: Ethics
 - Communication Training for Future Health Care Practitioners: Outcomes that Matters, how and what to measure?

Session Moderators

Each parallel session has been assigned a session moderator who is responsible for moderating the presentations and tight time-keeping. Please observe time in order to ensure all speakers have equal time to present. A folder with necessary instructions is available in each room. Please do not remove the folder.

Meals

Breakfast will be served on Monday with registration in the atrium. On Tuesday and Wednesday it will be served at 8:00 am in the dining room. Lunch will be served on Monday and Tuesday in the dining room on the 4th floor. Please refer to the schedule to see where food and drink for morning and afternoon breaks will be served.

Opening Reception

An opening reception for all attendees will be held on Monday from 6-7pm in the atrium of the main floor. You will be given two drink tickets for this reception upon check-in.

Conference Dinner

The Conference Dinner takes place on Tuesday evening in the Metcalf Trustees Center Ballroom on the 9th floor. This year's dinner will honor Dr. Elliot Mishler. The dinner costs \$75 and includes a beer and wine reception and a three course traditional New England summer meal. All those who are attending must have registered for the dinner prior to the conference. Details of the dinner will be included in the dinner ticket which will be given to those who have confirmed and paid for attendance ahead of time. Please bring this ticket to the dinner and place it next to your plate.

IT Facilities

There is a small computer lab located on the fourth floor in which is available from 8-6pm each day. Please respect others time as there are only 3 computers and 2 printers. Wireless internet will also be available to guests who bring their own laptops.

Publication Opportunities

All paper and poster presenters are encouraged to submit their contributions for consideration to the journal, Communication and Medicine. The deadline for submission is 30 September 2010. Plans are underway to introduce a designated issue of the journal, beginning 2011, comprising the COMET presentations. If the plan goes well the first such designated issue will appear in June 2011 to coincide with the next COMET conference being hosted in Nottingham, UK. All submissions will go through the routine peer review system. For more details on submission guidelines, visit (<http://equinoxjournals.com/ojs/index.php/CAM>). Please direct all other queries to (commed@cardiff.ac.uk).

Feedback forms

Please take a moment to fill in the feedback forms. Your response will help us to plan future COMET conferences.

Useful Telephone Numbers

Conference Coordinator: 617-414-1472

Taxi: Bay State Taxi - (617) 566-5000; Boston Cab - (617) 536-2600

Amtrak: 1-800-USA-RAIL (www.amtrak.com)

MBTA: (617) 222-5000 (www.mbta.com)

BU Police/Emergency: (617) 353-5362

Have an enjoyable conference!

The COMET Conference Committee

2010 Conference Chair: Barbara Bokhour

Conference Co-chair: Ellen Cohn

2010 Conference Committee: Mary Catherine Beach, Gemmae Fix,
Shannon O'Halloran

ACKNOWLEDGEMENTS

We would like to express our gratitude to the following people who formed the international reviewing panel for all submissions:

Mary Catherine Beach (Johns Hopkins University, USA)

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Paul Crawford (Faculty of Medicine & Health Sciences, University of Nottingham, UK)

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Lauris Kaldjian (University of Iowa Carver College of Medicine, USA)

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Branca Ribeiro (Lesley University, USA)

Srikant Sarangi (HCRC, Cardiff University, UK)

Peter Schulz (Institute of Communication & Health, University of Lugano, Switzerland)

A special thanks to our volunteers:

Wei-Jie Huang, Roselande Marcellon, Mahada Maya McDoom and Nora Mueller

We would also like to thank Zachary Bokhour for designing our program cover.

SCHEDULE AT A GLANCE

Monday June 28th 2010

Time	Activity	Location
8:00-9:25	Registration and Breakfast	Atrium (Ground Floor)
9:30-11:00	Conference Opening Plenary Session I	Auditorium (Ground Floor)
11:00-11:25	Morning Break	Atrium (Ground Floor)
11:30-1:00	Parallel Session 1	
1:00-1:55	Lunch	Dining Room (4 th Floor)
2:00-3:00	Parallel Session 2	(2 nd and 4 th Floor)
3:30-3:55	Afternoon Break	Atrium (Ground Floor)
4:00-5:30	Parallel Session 3	(2 nd and 4 th Floor)
5:30-6:00	Free Time	
6:00-7:00	Welcome Reception	Atrium (Ground Floor)

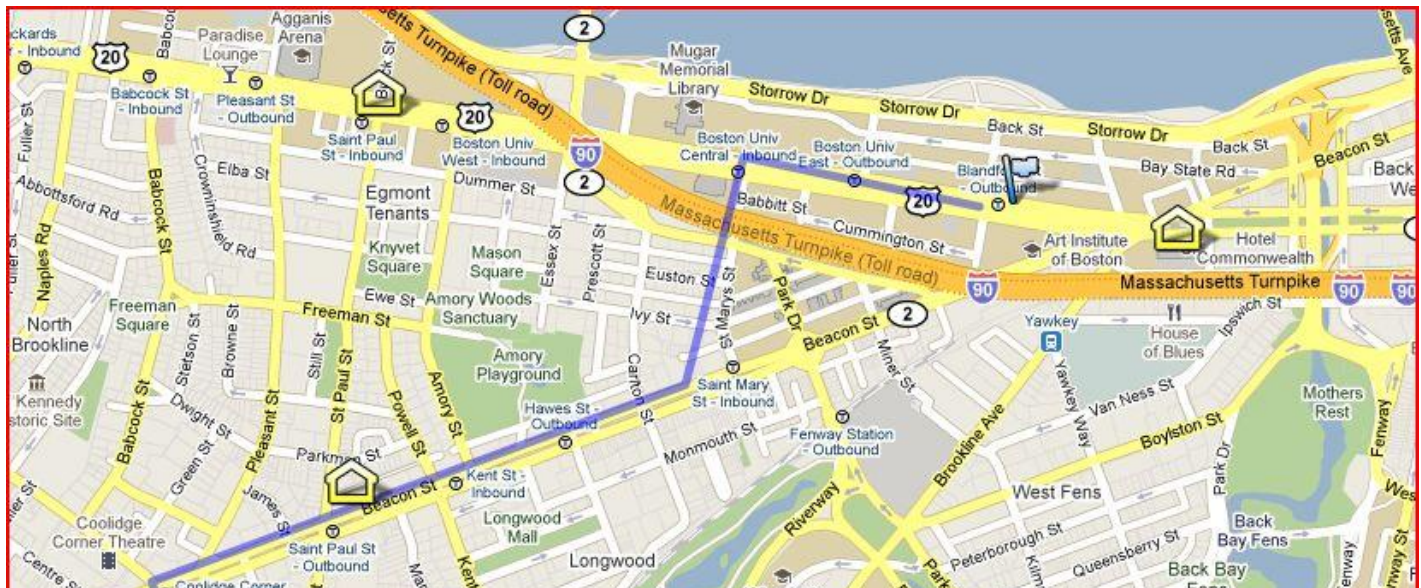
Tuesday June 29th 2010

Time	Activity	Location
8:00-9:00	Breakfast	Dining Room (4 th Floor)
9:00-10:30	Parallel Session 4	(2 nd and 4 th Floor)
10:30-10:55	Morning Break	Dining Room (4 th Floor)
11:00-12:30	Parallel Session 5	(2 nd and 4 th Floor)
12:30-1:30	Lunch	Dining Room (4 th Floor)
1:30- 3:00	Parallel Session 6	(2 nd and 4 th Floor)
3:00-3:25	Afternoon Break	Atrium (Ground Floor)
3:00-4:15	Poster Session	Atrium (Ground Floor)
4:15-5:45	Plenary Session II	Auditorium (Ground Floor)
5:45-6:30	Free Time	
6:00-7:00	Pre-Dinner Cocktails	Trustees Ballroom (8 th Floor)

Wednesday June 30th 2010

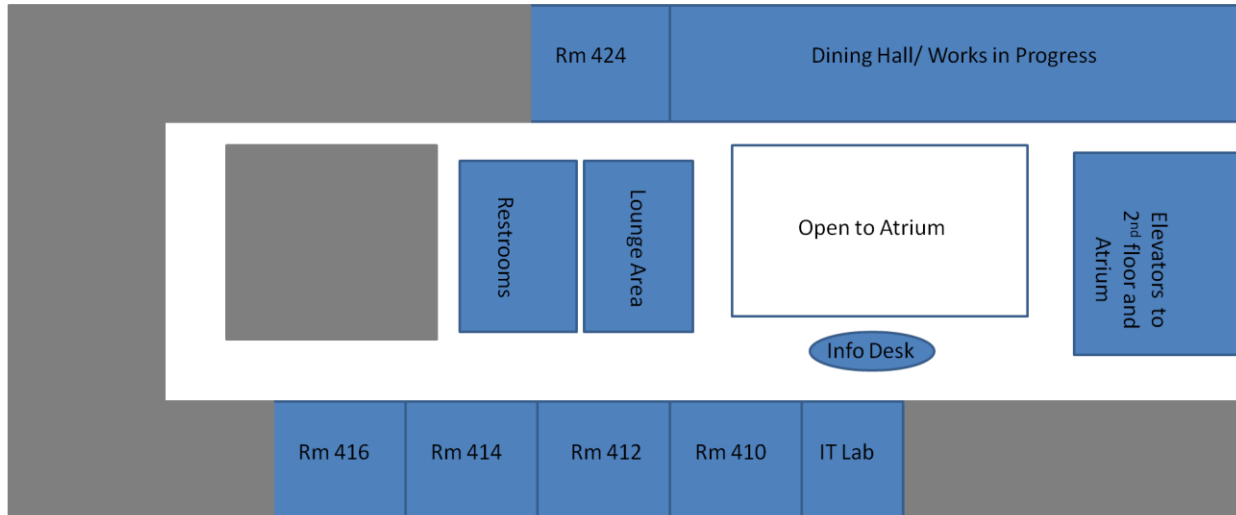
Time	Activity	Location
8:00-8:55	Breakfast	Dining Room (4 th Floor)
9:00-10:30	Parallel Session 7	(4 th Floors)
10:30-10:55	Morning Break	Dining Room (4 th Floor)
11:00-12:00	Parallel Session 8	(4 th Floors)
12:05-1:30	Plenary Session III Closing Remarks	Auditorium (Ground Floor)

CONFERENCE AREA MAP



CONFERENCE LOCATION MAP

Executive Leadership Center 4th Floor (Primary Conference Location)



DETAILED SCHEDULE: MONDAY

Room	410	416	222	414	412	208	Dining Rm
8:00	REGISTRATION AND BREAKFAST (ATRIUM)						
9:30	CONFERENCE OPENING and PLENARY SESSION I Welcoming Remarks by Dr. Robert Meenan Plenary Speaker Dr. Debra Roter (AUD)						
11:00	MORNING BREAK (ATRIUM)						
11:30	<p>Session 1 A</p> <p>Tse, Lai Kun <i>Transforming experience and learner transformation: An analysis of first year medical students' PBL reflections</i></p>	<p>Session 1 B</p> <p>Syed –Afzal, Samina <i>Communicating visual images: How sonographers frame aspects of risk and uncertainty for pregnant women during fetal normality ultrasound scans</i></p>	<p>Session 1 C</p> <p>Fix, Gemmae M. <i>"When I found out I had all the sickness": Using an illness-web to understand patient barriers to high blood pressure management.</i></p>	<p>Session 1 D</p> <p>Juraskova, Ilona <i>Improving decision-making in ovarian cancer: Development and evaluation of decision aids to help women make informed treatment choices</i></p>	<p>Colloquia A</p> <p>Patricia Geist-Martin (Organizer) <i>Communicating about CAM</i></p>	<p>Colloquia B</p> <p>Henrik Rahm (Organizer) <i>Constructing Communication as Care in a Scandinavian Care Setting Tools, Talk and Tasks</i></p>	
12:00	<p>Storey, Anne M. <i>Displaying professional expertise in medical case history presentations in PBL tutorials: a discourse analytic study</i></p>	<p>Hodgson, Jan <i>An Australian study of the process of prenatal genetic counseling</i></p>	<p>Davis, Boyd <i>Expanding explanatory models: The embodiment of agency and accountability in the talk of diabetics</i></p>	<p>Viale, Marisa <i>Psychosocial aspects of adherence to gynecological assistance by women with pathologies leading to uterus colon cancer in Rio de Janeiro</i></p>	<p>Patricia Geist-Martin Sarah Shoemaker Masha Sukovic Ramadurai Vandhana</p>	<p>Johan Barstad Tove Harnett Berith Hedberg (presenter) Ulla Hellström-Muhli Mette Muren-Gjerseth Henrik Rahm</p>	
12:30	<p>Gonçalves, José Carlos <i>Interaction and Discourse in</i></p>	<p>Phillips-Stoll, Aliza <i>Pushing Nature's</i></p>	<p>Gualtieri, Lisa <i>Blogging for Health:</i></p>				

1:00	LUNCH (DINING ROOM)						
2:00	<p>Session 2 A</p> <p>Glinert, Lewis <i>Manufacturers' prescription drug web sites: A grey area of discourse and ethics</i></p>	<p>Session 2 B</p> <p>Ford, Yvonne <i>The Things Nurses Talk About: Nouns in a Corpus of End-of-Shift Hand-offs</i></p>	<p>Session 2 C</p> <p>Solomon, Jeffrey <i>How Patients and Providers Negotiate Problem-Solving During Clinical Encounters: The Role of Speech Registers</i></p>	<p>Session 2 D</p> <p>True, Gala <i>"I felt like an Alien:" Combat Veterans' Reflections on Social Isolation and Social Phobia</i></p>	<p>Colloquia C</p> <p>Olga Zayts (Organizer) <i>Investigating prenatal genetic screening in Hong Kong as a discourse and an activity type</i></p>	<p>Colloquia B Cont.</p>	
2:30	<p>Rundblad, Gabriella <i>Communicating safe behaviour to the general public: A comparison of the different stages of a natural disaster</i></p>	<p>Hewett, David <i>A Survey of Communication between Hospital Doctors: Accommodation and Comprehension</i></p>	<p>Hydén, Lars-Christer <i>The listener's task in dementia</i></p>	<p>Kramer, Jessica <i>"Give them a voice": Therapists' perspectives on how the Child Occupational Self Assessment impacts their communication with school-aged children with disabilities.</i></p>	<p>Chin-Peng Lee Agnes M. Kang Alice Yau Olga Zayts</p>		
3:00	<p>Schweikardt, Christoph <i>Mobile phone health risk messages in the context of political debate on precautionary measures in Germany</i></p>	<p>Delany, Clare (presented by Jane Galvin) <i>Ethics and Communication in pain management for paediatric procedures lessons from play therapy</i></p>	<p>Beach, Mary Catherine <i>Improving Clinician Attitudes toward Patients with Sickle Cell Disease: The Impact of a Film Intervention</i></p>				
3:30	AFTERNOON BREAK (ATRIUM)						
4:00	<p>Session 3 A</p> <p>Stvan, Laurel <i>Stress Management: Corpus-based insights into Vernacular Interpretations</i></p>	<p>Session 3 B</p> <p>Juraskova, Ilona <i>Improving informed consent to clinical trials: A randomised controlled trial</i></p>		<p>Session 3 D</p> <p>Ellery, Natalie <i>'Jumping Hurdles': Experiences of Predictive Testing for Huntington's</i></p>	<p>Session 3 E</p> <p>Kupferberg, Irit <i>The Construction Of The Suicidal Self In Computer Mediated</i></p>	<p>Works-in-Progress for Round Table Discussion (Dining Hall)</p>	

4:30	<p>Frisch, Anne-Linda <i>Defining and Measuring Health Literacy: How Can We Profit from Other Literacy Concepts?</i></p>	<p>Saha, Somnath <i>Physician patient-centeredness and patient decision-making: a randomized study using video vignettes</i></p>		<p>Lerner, Barbara <i>Genetic Counseling Communication Patterns During the Disclosure of Genetic Susceptibility to Alzheimer’s Disease and Their Effect on Patient Outcomes</i></p>	<p>Smith, Catherine <i>Health Communication and the Internet: An Analysis of Adolescent Language Use on the Teenage Health Freak Website</i></p>	<p>1. Eliciting and Understanding Perspectives of Children & Adolescents Bastos, Liliana Bertell, Ida Pickering, Dawn</p>
5:00	<p>Connor, Ulla (presented by Kathryn Lauten) <i>Intercultural modeling of health literacy: A Study</i></p>	<p>Gabrielsson, Felicia Maria (presented by Roar Stokken) <i>Unempowering love: on patient choice and professionalism</i></p>		<p>Christensen, Kurt <i>Perceived personal utility of Alzheimer’s disease genetic susceptibility testing and its influence on post-test responses: Findings from the REVEAL Study</i></p>		<p>2. Teaching Communication to Health Care Professionals: Identity Construction Koenig, Regula Pinto Cadilhe de Assis Jácome, Alexandre José Ribeiro, Branca</p> <p>3. Telemedicine: Ethics Kreucher Sabrina (presented by Laryionava) Laryionava, Katsiaryna Keiser, Gerd</p> <p>4. Communication training for future health care practitioners: Outcomes that matter, how and what to measure? Barone, Susan Burke, Janice Rao Jaya Stokes, Adrian</p> <p>5. Mental Health: Communication</p>

DETAILED SCHEDULE: TUESDAY

Room	410	416	222	414	412	424	208
8:00	BREAKFAST (DINING ROOM)						
9:00	<p>Session 4 A</p> <p>Avdi, Elma <i>The influence of language and culture on medical student interviews</i></p>	<p>Session 4 B</p> <p>Saha, Somnath <i>Physician interracial anxiety, communication, and satisfaction among patients with HIV</i></p>	<p>Session 4 C</p> <p>das Graças Dias Pereira, Maria <i>Narratives of Community Workers in Tuberculosis Treatment</i></p>	<p>Session 4 D</p> <p>Todorova, Irina <i>Contextualizing pain and endurance in infertility treatment and IVF</i></p>	<p>Colloquia D</p> <p>Wen-ying Sylvia Chou (Organizer) <i>The role of illness narratives in health communication</i></p>	<p>Session 4 E</p> <p>Rugen, Kathryn <i>Computer Tailored Intervention in Primary Care to Promote Colorectal Cancer Screening</i></p>	<p>Colloquia E</p> <p>Srikant Sarangi (Organizer) <i>Decision-making in healthcare settings: A microethics perspective</i></p>
9:30	<p>Bower, Emily <i>Communication about the End-of-Life: Medical Students' Attitudes and Preparation</i></p>	<p>Laws, Barton <i>Physician Provision of Sexual Risk Behavior Counseling in HIV Care: Direct Observation Using Mixed Methods</i></p>	<p>Launer, John <i>A narrative based approach to teaching supervision skills</i></p>	<p>Rasmussen, Helen <i>Photo Elicitation in Health Care: Exploring Perceptions of Health, Happiness and Trust in Elderly Men and Women</i></p>	<p>Maria Caiata-Zufferey Wen-ying Sylvia Chou Amy Sanders Linda Squiers (presented by Suzanne Dolina)</p>	<p>Liu, Jen-Jyh <i>Pervasive Telemonitoring For Patients Living With Chronic Heart Failure: A Quantitative Study Of Telemedicine</i></p>	<p>9:00-10:30 Michael Arribas-Ayllon Per Måseide Gøril Thomassen</p> <p>11:00-12:30 Dana Kovarsky Kiek Tates Srikant Sarangi</p>
10:00	<p>Madiba, Mbulungeni <i>Language acquisition planning in South African universities: lessons from the Xhosa</i></p>	<p>Duncan, Rony <i>Parents' Understanding of Confidentiality when their Teenage Children See Clinicians Alone: a Matter</i></p>		<p>Lorenz, Laura <i>Using visual metaphors to communicate lived experience with an</i></p>		<p>Trondsen, Marianne (presented by Roar Stokken) <i>Between Love And Technology – On</i></p>	

MORNING BREAK (DINING ROOM)							
10:30							
11:00	<p>Session 5 A</p> <p>O'Grady, Catherine <i>The accomplishment of empathy in General Practice consultations</i></p>	<p>Session 5 B</p> <p>Laryionava, Katsiaryna <i>Neural Prosthetics – Public Understanding of Ethical, Social and Cultural Challenges</i></p>	<p>Session 5 C</p> <p>Elwy, A. Rani <i>Communicating Adverse Patient Events in Surgery: The CAPES Study</i></p>	<p>Session 5 D</p> <p>Dunkel, Anke <i>Targeting Health Messages in Switzerland</i></p>	<p>Colloquia F</p> <p>Karen Lutfey (Organizer) <i>Moving Beyond Disparities: Understanding Values and Responsibilities in Clinical Decision Making</i></p>		Colloquia E Cont.
11:30	<p>Dahm, Maria R. <i>'I can understand it is really difficult' - Challenges faced by international medical graduates in Australia</i></p>	<p>French, Kempa <i>Measuring the Suitability of Printed Patient Educational Materials</i></p>	<p>Dales, Jill <i>'Communicating with patients: the influence of prior assumptions'</i></p>	<p>Vicentini, Alessandra <i>Terminological challenges in medical communication: Toward a dictionary of bioethics terms</i></p>	<p>Courtney Jackson Karen Lutfey John McKinlay Jonathan Tritter Lisa Welch</p>		
12:00	<p>Woodward-Kron, Robyn <i>Towards standard setting for clinical communication skills: which criteria?</i></p>	<p>Palmer, Anthonia (presented by Thecla Ezeonu) <i>Routine Antenatal HIV Testing in Nigeria: an overview of the ethical and human right implications</i></p>	<p>Woskob, Larissa <i>Medical practitioner's perspectives on guilt as a motivational tool</i></p>	<p>Krahn, Timothy <i>Building mental health ethics literacy through film</i></p>			
LUNCH (DINING ROOM)							
12:30							
1:30	<p>Session 6 A</p> <p>Ford, Yvonne <i>Moves and Strategies in the Game of Nurses' End</i></p>	<p>Session 6 B</p> <p>Araujo, Meagan <i>The move towards standardized medical</i></p>	<p>Session 6 C</p> <p>Stokken, Roar <i>Chalk and Cheese – or Two Pies in a Pot</i></p>	<p>Session 6 D</p> <p>Jaeger, Kirsten <i>Culture-specific Assumptions and</i></p>	<p>Colloquia G</p> <p>Ulla Hellstrom Muhli (Organizer)</p>	<p>Session 6 E</p> <p>Major, George <i>Medical Signbank: Bottom-up sign</i></p>	<p>Colloquia H</p> <p>Invited Barbara Bokhour (Organizer)</p>

2:00	<p>Slade, Diana <i>Achieving effective clinician-patient communication in hospital emergency departments</i></p>	<p>Jacobs, Elizabeth A <i>Using a Video - interpreting Network to Improve Healthcare Communication for Limited English Proficient Patients</i></p>	<p>Allard, Jon <i>The Micropolitics of Clinical Teamworking</i></p>	<p>Chukwuneke, Felix (presented by Thecla Ezeonu) <i>Culture and Biomedical Care in Africa: the influence of culture on biomedical care in a traditional African society, Nigeria, West Africa</i></p>	<p>Michael C. Brannigan Jill Dales Roxana Delbene José Carlos Gonçalves Ulla Hellstrom Muhli</p>	<p>Dillon, Patrick <i>Moral Accounting and Membership Categorization in Primary Care Medical Interviews</i></p>	<p><i>State of the Art Communication Research in the US Department of Veterans Affairs</i></p> <p>Frankel, Richard Pope, Charlene Saha, Somnath</p>
2:30	<p>Manidis, Marie <i>Emergency Department Consultations: the complexity of ethnographic and discursive representation</i></p>	<p>Beach, Mary Catherine <i>Communication Measures and Patient Satisfaction: Are Associations Similar Across Ethnic Groups?</i></p>	<p>Kaldjian, Lauris <i>Ethical Issues Related to Communication Encountered by Third-Year Medical Students During Clinical Clerkships</i></p>	<p>Rahill, Guitlee <i>Cultural Adaptation of a Survey Instrument for Use in HIV Knowledge Research on a Rural Southern U.S. University Campus</i></p>		<p>Bartesaghi, Mariaelena <i>The Baker Act's revolving door: Provider's accounts, membership categories, and the management of moral accountability</i></p>	
3:00	AFTERNOON BREAK (ATRIUM)						
3:00	POSTER SESSION (ATRIUM)						
4:15	PLENARY SESSION II Welcoming Remarks by Dr. Karen Antman Plenary Speaker Dr. Clarence Braddock III (AUD)						
6:30	PRE DINNER COCKTAILS (TRUSTEES CENTER BALLROOM 9 th Floor) <i>Ticket Needed</i>						
7:30	CONFERENCE DINNER (TRUSTEES CENTER BALLROOM 9 th Floor) In Honor of Dr. Elliot Mishler						

DETAILED SCHEDULE: WEDNESDAY

Room	410	416	222	414	412
8:00	BREAKFAST (DINING ROOM)				
9:00	<p>Session 7 A</p> <p>Pettersen, Gunn (presented by Jan Rosenvinge) <i>Professional confidence as an output of an interdisciplinary educational program on eating disorders</i></p>	<p>Session 7 B</p> <p>Swinglehurst, Deborah <i>Voice and Authority in the Electronic Patient Record</i></p>	<p>Session 7 C</p> <p>Swoboda, Debra <i>Genetalk about Psychiatric Illness: Lay Understanding of the Genetics of Bipolar Disorder</i></p>	<p>Session 7 D</p> <p>Zurbruggen, Seraphina (presented by Anke Dunkel) <i>From Macro- to Micro-Culture in the field of health in Switzerland</i></p>	<p>Session 7 E</p> <p>Örülv, Linda <i>In the shadow of the future: Issues of control in early-stage progressive dementia</i></p>
9:30	<p>Flynn, Eleanor <i>The state of emergency communication skills teaching in Australian undergraduate Medical Education: Gaps, barriers and opportunities</i></p>	<p>Sarangi, Srikant <i>The burden of (non)treatment: Offline commentary during physical examination in primary care consultations</i></p>	<p>Saunders, Benjamin <i>"I Just Don't Want to be Thought of as the Girl Who's Ill": Young Adults' Construction of Others' Perceptions in Accounts of Chronic Illness</i></p>	<p>Poe, Pamela <i>Direct-to-Consumer Prescription Drug Ads in the US: A Qualitative Study of Older Adults Using Grounded Theory to Study DTC Ad Response</i></p>	<p>Antelius, Eleonor <i>Communicative Disability and Stories: Towards an embodied conception of narratives</i></p>
10:00	<p>Stokes, Adrian <i>Is there such a thing as a 'teaching style', and does it matter?</i></p>	<p>Clerehan, Rosemary <i>Research into practice: Nuancing identities of providers and patients</i></p>	<p>del Carmen Alvarez-Gordillo, Guadalupe <i>Social Constructions of the Body among Youth in Comitán, Chiapas, Mexico</i></p>	<p>Schulz, Peter <i>Appealing to the Authority of the Many in Direct-to-Consumer Advertising: an Argumentative Perspective</i></p>	<p>Hydén, Lars-Christer <i>Non-verbal vocalization and intersubjectivity in Alzheimers disease</i></p>
10:30	MORNING BREAK (DINING ROOM)				

11:00		<p>Session 8 B Chang, Wan-ting <i>Making Open Questions Work: Towards Patient-centered Communication</i></p>	<p>Session 8 C Duncan, Rony <i>Psychologists who Breach Confidentiality with Adolescent Clients: Transparent Communication as a Means of Minimising Harm</i></p>	<p>Session 8 D Rustad, Hanne <i>Intensifiers as a strategy for communicating health risk and normality concerning cardiovascular diseases</i></p>	<p>Session 8 E Spires, Ann <i>Opioid Prescribing for Chronic Pain: Reflections on Shared Decision-making</i></p>
11:30		<p>Galvin, Jane <i>Sharing big decisions with children and families: An occupational therapy example</i></p>	<p>Seixas, Azizi <i>"Risky" Business: Understanding, Investigating and Communicating Risk in Youth Delinquency</i></p>	<p>Matarese, Maureen <i>Dynamic Discourse: Time Talk in Caseworker-Client Interaction</i></p>	<p>Adams, Ann <i>Empowering patients and clinicians to communicate about risks associated with mental health problems</i></p>
12:00	<p>PLENARY SESSION III and CONFERENCE CLOSING (AUD) Welcoming Remarks by Dr. Gloria Waters Plenary Speaker Dr. Alan Radley</p>				

PLENARY SESSIONS

DR. DEBRA ROTER

Plenary Session I: Monday June 28th 9:30 am

Dr. Debra Roter

**Professor of Health, Behavior & Society at the Johns Hopkins
Bloomberg School of Public Health**

Second Sight: Extending Insight into the Patient Experience of Care

It is both the willing suspension of disbelief and the power of empathy that opens a second, albeit secondary, window into the world of patients and physicians. The powerful effect of simulations to induce experimental realism is evident in the now common use of standardized patients to assess medical performance. Many studies have found that physicians judge standardized patient encounters to be highly realistic and often indistinguishable from those with actual patients. Important implications from the stream of research, however, go far beyond physician acceptance of simulated patients as a stand-in for actual patients. It opens a variety of methodological possibilities by which individuals may accept simulations as a realistic representation of a patient experience of which they may vicariously participate. It is in this realm that the power of empathy, the ability to stand in the shoes of another, when coupled with a willing suspension of disbelief, that provides the mechanism by which insight into the patient experience may be derived by proxy.

Proxy or analogue patients are distinct from standardized patients in that they

are usually untrained subjects recruited to imagine that they are a patient depicted in some medical circumstance, often with provider or communication attributes experimentally manipulated. The circumstance may be portrayed as simply as a written vignette, as authentically as actual or simulated audio or video recordings of a medical encounter, as abstractly as a 10 second “thin slice” segment of exchange, or as innovatively as a physician avatar providing care in a virtual medical visit. In these ways, analogue patients become the substitute for actual patients presenting perceptions and judgments of care that may otherwise escape study.

The objectives of the address are threefold: first, to describe a variety of studies in which analogue patients have been used to assess dynamics and consequences of patient-provider communication, second, to overview the diverse nature of the questions addressed, some of which can only be addressed in this manner for ethical, methodological or logistical reasons; and, finally to discuss the challenges, pitfalls and potential of this approach for future studies.

PLENARY SESSIONS

DR. CLARENCE BRADDOCK III

Plenary Session II: Tuesday June 29th 4:30 pm

Dr. Clarence Braddock III

Professor of Medicine & Associate Dean for Medical Education at Stanford University School of Medicine

Shared Decision Making as a Tool to Reduce Healthcare Disparities

Despite widespread recognition of the magnitude of disparities in health and healthcare in the United States, data continue to show their persistence, in some cases even worsening. Although improving access to health care services and efforts to reduce poverty are necessary components of the effort to reduce and eliminate disparities, there has been increasing recognition of the contribution of the clinician-patient interaction to disparities. Social science research showing systematic differences in how clinicians think differently about clinically identical cases when they are presented with racial, ethnic, or gender cues underscore the powerful influence of bias. This growing body of work has raised the importance of communication in health care to new levels, as a set of

practices that if done well may ameliorate the influence of bias in worsening disparities. In particular, shared decision making offers a way to assure that all patients are given a balanced set of choices, and to guide clinicians through dialogue aimed at reaching a mutual decision that reflects the patient's unique and socially constructed values and preferences. In this talk, I will review some of the empirical evidence emerging about the link between communication, shared decision making, and disparities, and then advocate a vision for how increased emphasis on shared decision making at both the clinician and organizational levels will be an important strategy in combating disparities in health and healthcare.

PLENARY SESSIONS

DR. ALAN RADLEY

Plenary Session III: Wednesday June 30th 12:00 pm

Dr. Alan Radley

Professor of Social Psychology in the Department of Social Sciences at Loughborough University, UK

The Art of the Consultation

The work of the doctor in the consultation involves listening, reformulating and feeding back information to patients. This is facilitated by an organisation of the clinic that abstracts and transforms information to promote efficient and successful management of the patient's condition. However, this view of medical practice has been held alongside the belief that successful doctoring also involves other ways of relating to patients, sometimes summarised under terms like 'skill' or the 'voice of the lifeworld'. In this talk I show how the doctor is able, through the use of proto-stories and bodily expression, to create a space in which he or she becomes present to the patient in a different way. As a consequence the patient is able to 'lay down her own stories' in ways that enable a different conception of time to be realised in the consultation. This has

implications for the management of chronic conditions in particular, where past experience of both the condition and its treatment can play important roles in the meeting. Drawing out distinctions between *medico-scientific* and (what I term) *medico-presentational* ways of signifying provides the basis for legitimating what has often been referred to (quite appropriately) as 'the art of medicine'. These distinctions - some having been recognised before by social scientists - also have important implications for the way that we study medical communications in the clinic, particularly with regard to assumptions built in to forms of data gathering and analysis. The message of this talk is that the effective deployment of both ways of signifying are crucial to good doctoring, even more so in an age of rapid technological advancement.

COLLOQUIA

Colloquia A Monday June 28th 11:30 – 1:00 pm

Communicating about CAM

Patricia Geist-Martin₁; Barbara F. Sharf₂

San Diego State University₁; Texas A & M University₂, USA

Complementary and alternative medicine (CAM) refers to "health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques, applied singularly or in a combination to treat, diagnose and prevent illness or maintain well-being." These healing practices may be used alongside, integrated with, or instead of conventional or allopathic medicine. While the efficacy of a few modalities for specific ailments have been strongly demonstrated in scientific literature (e.g., acupuncture), U.S. conventional medicine remains largely skeptical of CAM. However, the American public seems to feel differently. Approximately eighty-three million (38%) adults and 8.5 million (12%) children are using some form of CAM, resulting in an annual, out-of-pocket expenditure of nearly \$34 billion. Furthermore, CAM use is increasing. Oddly, health communication

researchers have been slow to acknowledge this trend and to focus on CAM practices as sites of relational and mediated communicative experience. This proposed panel will review extant health communication research (Geist-Martin & Sharf), showcase three ongoing projects that illuminate communication about CAM in previously ignored situations—how CAM is portrayed in popular media (Sukovic), why parents decide to place their children in CAM treatments (Ramadurai), and how family and community roles in holistic childbirth differ across cultures (Shoemaker). We then offer an agenda for future health communication scholarship on this topic (Sharf & Geist-Martin). This colloquium will address themes of client-professional encounters; identities and experiences of health, illness and treatment; and media and health communication.

Patricia Geist-Martin₁; Barbara F. Sharf₂

San Diego State University₁; Texas A & M University₂, USA

Health Communication and CAM: Where We've Been and Directions We Could Take

Please note: For purposes of the proposed colloquium, our paper will be divided in two parts, a prologue and an afterword, serving as "bookends" for the other papers in the panel. In part based on our own published work as well as that of others, this is a conceptual and agenda-setting paper (and does not fit well within the issues, methods, findings, implications format, though issues, findings and implications are integrated in our description)..

Part One, Where we've been: Though the health communication literature related to CAM is relatively scant, over the past decade, studies are slowly beginning to accumulate. In our introductory remarks, we will locate and clarify the sometimes confusing, overlapping vocabulary used in conjunction with CAM, and reference significant studies that explain how

communication has been framed as an issue related to CAM. This overview will serve to contextualize the next three papers presented in this colloquium Part Two, Directions we could take: Given that there is much to be accomplished to develop a body of knowledge about CAM as an important component of health care activity and as a site of relational and mediated communication, we will offer a tentative research agenda employing categories such as practitioner-client interaction, practices and perceptions of CAM within varied organizational contexts, media depictions, and entertainment-education. Within each category, we will pose heuristic questions and challenges intended to generate discussion within conference attendees and the larger community of health communication scholars.

Masha Sukovic

Texas A & M University, USA

Quack Science or Miracle Cure?: Representations of Complementary and Alternative Medicine in Mainstream Movies and TV Shows

Background: A recent increase in popularity of alternative and complementary medicine (CAM) in the U.S. and other Western countries indicates that CAM has become a permanent feature of our cultural landscape. One of the facets of culture is the popular media, which permeates our world in numerous and complex ways. Stories presented in the popular media, therefore, can tell us something about common beliefs and values that people hold, and have a potential to communicate pertinent issues pertaining to culture by offering scripts for action and reinforcement for choices made. Therefore, media representations of important issues in our culture have a significant role in determining ways that we think and feel about those issues. This paper investigates representations of complementary and alternative medicine and medical practitioners in

the popular media, more specifically mainstream movies and TV shows. Method and findings: This paper provides an in-depth analysis of eleven mainstream media texts, including *Medicine Man*, *Grey's Anatomy*, *Friends*, and *Sex and the City*, and identifies five main themes: CAM as a reflection of the frontier myth; CAM practitioner as the dark Other; CAM as quack (or junk) science; CAM as a miracle cure; and CAM as the last hope, or a method used when everything else fails.

Implications: The possible effects that cultivation of media representations of CAM may have on audiences include reinforcing existing racial stereotypes, generating misconceptions of and creating barriers to using CAM, and/or causing too much reliance on CAM and avoidance of conventional medicine.

Vandhana Ramadurai

Texas A & M University, USA

The Emergence of the Postmodern Parent: An Analysis of CAM Use by Parents

Background: The use of complementary and alternative medicine (CAM) among children is increasing in the United States. This trend is especially true among children with chronic illnesses and disability. After accounting for sociodemographic variables, dissatisfaction with medical outcome did not predict people's attitudes about CAM. Dissatisfaction with doctor-patient relationship and adherence to postmodern values of health were better and significant predictors of attitudes towards CAM¹.

Objective: Research was conducted to understand the motivations and experiences of 16 parents who choose CAM for their children in Texas.

Method: Through in-depth interviewing and thematic analysis, this project investigates beyond the demographic variables that link parents and children to CAM use to present a detailed analysis of parent's use and experiences

of CAM for their children.

Findings: The data collected provide insight into the various reasons for using CAM. The reasons for limited disclosure of CAM use to pediatricians were investigated in this study and practical suggestions are provided to address this problem. The interviews also reveal how the communication between the alternative practitioner and the parent satisfies a holistic approach that parents desire.

Implication: The findings demand a new model for understanding parents' experiences with alternative treatments that can benefit health care providers and scholars. In terms of the integrative approach to health, the study helps health communication scholars develop models of communication that would enable conventional doctors and alternative practitioners to collaborate with each other.

Sarah Shoemaker

San Diego State University, USA

The Role of Family and Community in Holistic Health: Birthing Stories of Latina Immigrants to the United States

Background: Prenatal care, birthing, and postnatal care methods of modern medical practices and time-held traditions vary across cultures. In addition to medical treatments, many mothers choose to incorporate holistic practices in the birth process. Holistic birthing practices include acupressure, massage, herbal remedies, meditation, and hypnosis. Furthermore, the literature supports the integration of holistic practices in pre/postnatal care in reference to overcoming poverty, women's education/empowerment, and anticipatory guidance for new mothers. The involvement of family members and community in the birth process varies from culture to culture. Therefore, through approaching childbirth with a holistic lens, it seems appropriate to not

only consider physical and spiritual components, but also the roles of family and community and their variations across culture.

Method: This research is designed to explore recent immigrant cultural holistic practices, particularly the involvement of family and community, in childbirth. [The work is still in process; findings not yet available.]

Implications: Doctors may then better understand the cultural differences regarding holistic birth practices, which may lead to improved communication skills and the quality of care during intercultural medical interactions.

Colloquia

Colloquia B Monday June 28th 11:30 am-1:00 pm

*Constructing Communication as Care in a Scandinavian Care Setting
Tools, Talk and Tasks*

Coordinator: Henrik Rahm

Lund University, Centre for Languages and Literature, Sweden

The aim of the colloquium is to discuss communicative challenges in public care from perspectives of participation, involvement and implementation of policies and practices among care givers and care recipients. Of particular interest are the discursive practices where actors have and are given authority to interact within certain frames. The notion communication as care is analyzed both as a tool for care policies and care work, and as a perspective of care. Thus, there are analyses of contextual settings, care activities, care perspectives and actors' interactional behavior. The colloquium contains presentations by Scandinavian researchers from different disciplines with a common focus on how

communication as care is constructed in a Scandinavian care setting. The presentations deal with common questions such as:

How are care policies, care responsibilities and roles of care transformed, interpreted and implemented in discursive practices?
How are tasks of care and roles of care realized in communication as care?
How is communication used as a tool in care encounters?
What are the commonalities and discrepancies in realizing communication as care, both within a Scandinavian public care context and compared to other care contexts?

Henrik Rahm

Lund University, Centre for Languages and Literature, Sweden

*Constructing Communication in Elderly Care the Challenges of
Adopting to the Target Group(s)*

Background and objective: The aim is to critically discuss the ideals of plain language in texts from Swedish authorities. Since the 70s, there has been an extensive work in implementing these ideals which can be subsumed as well-arranged texts with logical structure, carefully prepared content structure, relevant lexical choices, simplified syntax, lucid layout and adopting to the target group.

Research questions: How are the ideals of plain language interpreted and realized?
Which are the target group(s)?
How can adjusting to the target group be problematized?
How is presentation for the general public negotiated?

Methods: Public information from the elderly care in the municipality of

Malmö is analysed. Focus group discussions are conducted with officials regarding ideals of communication with the general public. A leaflet presenting the municipal elderly care (produced within Malmö), is a point of departure for the discussions, aiming at an understanding of how plain language is interpreted and implemented, but also how the presentation of elderly care is negotiated.

Findings: The care manager has conflicting roles as a social worker judging the nursing and social needs of the individual as well as a decision maker.

There are restricted possibilities obtaining further information. Written material is only adjusted to a fictive average target group.

Ulla Hellström Muhli

School of Life Sciences, University of Skövde, Sweden

*Verbal Strategies for Supportive Approach in Need Assessment
Dialogues with Elderly*

Background: Need assessments dialogues are framed by a bureaucratically order which fuel communicative problems, negative for the elderly clients' well-being as not understanding the information, feeling of patronage patterns, etc. However, supportive utterances and commentaries are frequently used to accomplish the goal of individual-centered care and the utterances serve indirectly a purpose of supporting the individuals' well-being. Thus, the dialogues are tools for constructing communication as care.

Aim: The aim is to explore the use of supportive utterances and commentaries as recourses and verbal strategies for wellbeing in constructing communication as care.

Methods: Supportive utterances are here understood as positively affective speech acts and are analyzed in interaction between elderly clients and care managers. The dialogues were recorded, transcribed and translated verbatim. An

activity analysis of institutional settings and categorization of supportive utterances was made. There was a twofold focus: (i) how professionals initiate supportive utterances, and (ii) how the elderly clients orient to such utterances.

Findings: I am making two major points about verbal strategies in need assessment dialogues. Firstly, each supportive utterance serves several purposes, one of them to confirm the expert role of the case manager. Secondly, verbal strategies in client-expertise dialogues reflect resources that are essential in the expert system to accomplish goals of individual wellbeing.

Implications: Knowledge about supportive utterances as verbal strategies contributes crucially to feelings of well-being and to attitudes toward the need assessment dialogues, and furthermore, how the dialogues can be client-oriented and pedagogical.

Eleni Siouta; Berith Hedberg (presenting author)

School of Health Sciences, Jönköping University, Sweden

Shared Decision Making talk in Medical Encounters

Background and objective:

Research has showed that when patients have information about procedures, treatments and therapies, they make decisions that reflect their values and preferences. Patients reports higher rates of satisfaction when a shared decision making (SDM) approach is used. To prevent the risk factor of ischemic stroke, most patients' affected by atrial fibrillation (AF) are treated by anticoagulation treatment on a long-term basis. The aim of the study is to discuss how SDM is communicated during a consultation encounter between medical cardiologists and patients with AF.

Methods: Twelve hospital consultation encounters between cardiologists and patients were video-recorded. After verbatim transcription the data were analyzed from an inductive, qualitative approach.

Findings (preliminary):The main activity during the consultations was educational talk. The cardiologists' dominated the talk which was technically focused with short parts of socio-emotional content. The voice of the patient concerned their social life and the health situation experience. When talking about the anticoagulation treatment the cardiologists' used a motivational way to take the treatment of warfarin reducing the risk of ischemic stroke.

Implications: To get the patient involved in the decision making process, physicians and other health professionals need to act from a shared decision making perspective. There is an obvious need that health professionals learn to use and practice shared decision making as care, where decisions will be grounded in the patients' values and preferences.

Tove Harnett

Institute of Gerontology, Jönköping University, Sweden

Constructing Triviality in Nursing Home Care

What is important and what is trivial for a person in a nursing home?
And how can we understand why nursing home staff say that it is important to let older people exercise influence, while simultaneously justify actions when they force an old man to bed against his will or restrict an old lady from choosing what blouse to wear?

This study explores how staff members use communication as care in nursing home settings. The aim is to analyze how staff explain and justify restrictions of older people's everyday influence and thereby to expose staff members' folk logic.

The material is based on qualitative interviews with nursing home staff and ethnographic data from five months nursing home observations. The analysis was guided by the principles of analytic

induction. Scott and Lyman's concepts of accounts were used as theoretical approach.

The staff argued that, in general, restricting older people's influence is condemnable. However, through the use of a "rhetoric of trivialization", staff created a context in which it appeared logical to break with the principle of residents' right to influence. Their rhetoric functioned as a power resource, through which older people's views were "made trivial" by the ways they were communicatively treated by staff. While previous researchers have explained residents' limited autonomy by factors such as lack of staffing and time, they have often overlooked everyday talk. This study shows that by recognizing how older people's influence is "made trivial", we gain an understanding of how to accomplish just the opposite.

**Johan Barstad₁; Roar Stokken; Siv Osdal; Solrun Osdal;
Torstein Hole**

Patient Education Research Center, Norway₁

Care in the Air: Heading Home After Interhospital Transfers

Returning after hospital treatment, patients generally spend only short time in transit. Having been transferred from one hospital to another, the transition time may be considerably longer, especially in rural areas. Even if cured – the patient may still feel need of care. We ask if the discharge process manages to extend the care-aspect of hospitalization so it can follow through the transition from leaving the hospital until the patient is returned home or in the care of the local healthcare system.

Our study is based upon a postal survey on information issues to all patients experiencing Acute Coronary Syndrome, transferred from two local hospitals to a regional hospital for treatment, over a period of one year. We utilize data in relation to the transport from regional hospital back to home/local hospital.

We found that the information given prior to discharge did influence how the transition between regional hospital and local hospital/home was experienced. We also found that it was more important to feel informed than to be informed. That the context of the information was less important than the information process itself

Other studies have shown that general trust in the health care system is decreasing. Getting back home without experiencing any problems or hindrances is considered an integrated and important part of the patient's experience of how the health care system works. When the expressed goal is to establish a seamless health-care that is focused upon the individual patient's needs, negative experiences in transit will contribute to diminishing trust.

Mette Muren Gjerseth₁; Roar Stokken; Johan Barstad

Sunnmore Hospital Trust, Norway₁

Informative Care: patient educative initiative and satisfaction during hospital stay

Introduction: This study investigates how a patient educative initiative contributes to satisfaction during hospital stay due to a total hip replacement. Patients are assembled for a so-called introduction day one to two weeks ahead of surgery. This day involves participating health professionals offering their views and perspectives on the future treatment. Surgeons or other members of the surgery team offer some insights on the operation itself, nurses on pain treatment, physiotherapists on training etc.

From an organization perspective, the benefits concern two diverse, but related aspects: 1) to make the health professional's job easier, since the patient is better prepared to partake in the activities, and 2) smoothening logistics since the patient gains better knowledge about the procedures and ways of doing things, and reciprocal that

the system gets to know the patient better.

Research question and method: We investigate whether the patient educative initiative is perceived to contribute to a qualitative better stay for the patient. A questionnaire is distributed to the patients before they are discharged from hospital. The questionnaire is a combination of closed and open questions, and concerns experienced degree of preparedness and how well suited their preparedness was relating to that actually happened.

Discussion: On basis of the study we discuss changes concerning syllabus and arrangements of the information-day. We further discuss how the information day contributes to perceived quality. The discussion is related to background variables such as age, gender, marital status, previous hospitalization and education level.

Colloquia C Monday June 28th 2:00 – 3:30 pm

Investigating prenatal genetic screening in Hong Kong as a discourse and an activity type

Organizer: Olga Zayts

University of Hong Kong, Hong Kong

In this colloquia we take a discourse analytic perspective and examine prenatal genetic screening (PGS) in Hong Kong. Available discourse studies of PGS have focused on monolingual (predominantly English) discourse. In this colloquia we examine Hong Kong data where PGS involve participants with diverse sociocultural backgrounds. These intercultural encounters present challenges to healthcare providers: clients bring in different cultural perceptions toward issues of, for example, having a child with genetic abnormalities or termination of pregnancy; they also display various language proficiency and levels of understanding.

Our panel builds on a large-scale study of PGC in Hong Kong. Currently our data comprise over 100 patients originating from various parts of Asia-Pacific Rim, Europe and the USA. The study involves academic collaboration between linguists and healthcare providers around the world (Hong Kong, the UK and the US).

Our objectives in this panel are two-fold: first, drawing on the concepts of activity type (as ‘means of characterizing setting’) and discourse type (as ‘way of characterizing the way of talk’) (Sarangi 2000) we aim to depict how PGS is enacted discursively in the intercultural context of Hong Kong. Secondly, we discuss how the diverse sociocultural backgrounds of both healthcare providers and clients impact on the three ‘crucial activities’ (Sarangi 2000) of genetic counseling, namely, information-giving, advice seeking and decision-making.

Through a detailed analysis of PGS, we hope to get a better understanding of the complex relationship between the sociocultural context, the background of the participants and the accomplishment of the PGS activities in situ.

Olga Zayts₁; C.P. Lee (presenting author); Stephanie Schnurr

University of Hong Kong₁, Hong Kong

Introduction to the Panel: Prenatal Genetic Screening in Hong Kong as a Site for Activity Analysis: Re-Establishing the Importance of Participant Structure in Intercultural Encounters

In this paper we draw on the notion of activity type and examine Prenatal Genetic Screening (PGS) in Hong Kong. Activity type is defined as ‘a fuzzy category whose focal members are goal-defined, socially constituted, bounded events with constraints on participants, settings, [...and] the kind of allowable contributions’ (Levinson, 1992). While previous studies suggest that the structure and goals constitute prime components of activity type, we maintain that in intercultural encounters, participation structure takes precedence over other components and has a direct impact on how the activity is realized discursively.

In our study of PGS clients come from diverse backgrounds. The structure of PGS activity varies accordingly: for example, Filipina clients, predominantly Catholic, often come with a ‘pre-made’ decision not to undergo genetic screening and maintain their pregnancy

regardless of the genetic diagnosis. This makes the information-delivery redundant, and the healthcare providers manage these decisions in order to ensure that the clients understand their implications. The goals of PGS also vary depending on the clients’ socioeconomic background. With migrant workers who attend PGS on their own and lack the immediate familial support in Hong Kong, healthcare providers often have to manage explicit advice-seeking to ensure that the decision reflects the clients’ values.

The complexity of participation structure presents challenges to the healthcare providers who balance meeting the institutional goals of PGS and the clients’ concerns. Our analysis re-establishes the importance of participation structure in intercultural encounters and sheds lights on some of the challenges that participants of these encounters face.

Virginia Wake Yelei; Olga Zayts (presenting author)

U.S. Census Bureau, USA

Discourse Structuring of Factual Information for Presenting Prenatal Genetic Testing Options

Presenting prenatal testing options is one of the most important agendas in Prenatal Genetic Screening (PGS). How the options are presented to the clients has direct impact on their decisions. However, pros and cons of each prenatal testing option are not straightforward and factual information becomes evaluative when it comes to a specific decision-making process.

This study examines the healthcare providers' way of organizing factual information into a presentation of prenatal testing options and how the presentation can contribute to their clients' decisions. The data comprise 28 video-recorded PGS sessions. The healthcare providers are native speakers of Cantonese using English as their professional language. The clients are from diverse socio-cultural backgrounds who speak English as their native or non-native language.

Our focus is on the healthcare providers' discourse strategies in presenting the prenatal testing options. We analyze their choice of words, how they arrange the elements of the information (such as test nature, risk, cost, and location), and how their clients respond to the presented options. The cultural frame underlying their structuring of information-giving is also examined.

This study shows that the presentation of the factual elements is heavily framed in the healthcare providers' perspective. This indicates that the means to organize medical information has an impact on the clients' understanding of their available options and their decisions accordingly. It is, therefore, important to pursue further examination of the discursive organization of the presentation of factual medical information in clinical practice.

Alice Yau; Olga Zayts

University of Hong Kong, Hong Kong

'Your Test Result Is Sort Of, Cut Off ... Higher Than Average': Delivery of Positive Screening Result for Fetal Down Syndrome in Prenatal Genetic Screening in Hong Kong

In this paper we employ a discourse analytic perspective and examine how a positive screening result for fetal Down Syndrome is presented to clients. These clients are identified as high-risk group therefore they are recommended follow-up diagnostic testing. Currently our data comprise 6 clients and the follow-up interviews with healthcare providers and clients.

The delivery of a positive screening result is an interactionally complex activity with several intertwined discourses at play. First, the healthcare providers need to find a balance between the predictive nature of the test results and presenting them in a credible or expert manner (Sarangi and Clarke, 2000). Secondly, as the results are likely to find an affective response from the clients, the healthcare providers also engage in offering re-

assurance to clients. In addition, in this paper we argue that in the sociocultural context of Hong Kong, the diverse sociocultural and linguistic backgrounds of the participants further exacerbate these interactional challenges. Cultural beliefs and perceptions have a critical influence on what would be considered as appropriate or acceptable course of actions in the circumstances of the positive screening result. Linguistic proficiency may interfere with the understanding of the information provided to clients about the test results. In this paper we examine the discursive practices of the healthcare providers and how in delivering the positive screening results they balance the predictability of these results and their medical expertise while at the same time offering reassurance to the patients and taking into consideration the client's sociocultural and linguistic background.

Agnes M. Kang; Olga Zayts

University of Hong Kong, Hong Kong

'Early Decisions' In Prenatal Genetic Screening Sessions: Negotiating the Accomplishment of Informed Choice

In this paper, we focus on the clients' presentations of decisions regarding Prenatal Genetic Screening for Down Syndrome. While the majority of clients present their decision to the healthcare providers at the decision-making phase after receiving information about genetic screening options (what we refer to as 'timely decisions'), clients may also present their decisions early on in the consultation, e.g. during the history-taking or the educational phases (what we refer to as 'early decisions'). When decisions are made earlier in the consultation, this may interfere with information-giving process and clients' informed choice regarding prenatal screening.

Our focus is on the discursive practices involved in negotiating early decisions. We analyze: 1) how 'early decisions' are presented by clients; and 2) how these decisions are responded to by healthcare providers. We find that 'early decisions' are more often accompanied by accounts, or justifications, than the "timely decisions". We discuss various types of accounts presented by clients, including medical accounts and self-oriented accounts. The interactional consequences of the type of account that is given is examined in the data to show that, in general, the use of accounts rarely leads to early decisions being accepted by the healthcare providers. But when accepted, we illustrate that certain types of accounts tend to be more persuasive than others.

Colloquia D Tuesday June 29th 9:00-10:30am

The Role of Illness Narratives in Health Communication

Coordinator: Wen-ying Sylvia Chou

National Cancer Institute, USA

Storytelling has become an increasing popular form of communication about health. Whether on the Internet, among individuals suffering from particular illnesses, or in health promotion programs, personal experience narratives have been found to be powerful tools of shaping perceptions and influencing behaviors. The growing interest in narrative touches upon many aspects of the conference themes, including Identities and Experiences of Illness, Media and Health Communication, Public understanding of Health and Illness, Communicating Risk and Uncertainty, and Tailoring Health Messages.

What do stories elucidate illness experience and impact discourses surrounding health? How can explications of authentic stories inform health communication efforts? Our panel will address these questions through diverse analytic approaches. From passive observations of texts and public discourse, in-depth interviews, to intervention studies, the panel will bring together facets of illness narratives to

brainstorm on its role in health communication. Panelists will:

- Describe results from an analysis of cancer survivors' stories posted on YouTube, focusing on verbal construction of a diagnosis and the key components to diagnostic narratives;
- Use in-depth interviews with chronic pain sufferers to report on how individuals use narratives to reveal techniques for self-management;
- Present an analysis of the Lance Armstrong Foundation media campaign, emphasizing the use of sporting metaphors to frame cancer survivorship;
- Share results on the analysis of patient-child conversations about cancer (through StoryCorps program), focusing on the effects of stories on communication about cancer within families.

The shared research questions will stimulate in-depth discussions on narrative research methodologies.

Wen-ying Sylvia Chou; Yvonne Hunt; Erik Augustson

National Cancer Institute, USA

Constructing a Cancer Diagnosis on Youtube: A Linguistic Analysis

Background: User-generated health-information, including personal experience stories, has proliferated with the rapid growth of social media and online video content. Discourse analysis can provide important clues to the way new media (e.g., through YouTube) are being used to share personal experience by individuals with a cancer diagnosis. The study examines cancer survivors' personal stories posted on YouTube, with the goal of identifying common narrative components and tracing the posters' verbal construction of the diagnosis experience.

Methods: The (English-language) site (www.youtube.com) was queried using search terms "cancer survivor" and "cancer stories". Following our inclusion criteria, thirty-five videos were extracted and transcribed for in-depth narrative analysis. The team-based analysis was iterative; 3 researchers separately coded the videos and discussed results consensus was reached.

Findings: In addition to being characterized by the language of agency and high level of emotional engagement, a shared element among the stories was the diagnostic narrative, i.e. segment of the story recounting the event of a cancer diagnosis. Shared linguistic components were identified in these diagnostic narratives: the portrayal of a sense of normalcy, explicit temporal orientation to time of diagnosis, direct reported speech, generic second-person pronoun ("you"), and depersonalized references to medical personnel.

Implications: With increasing Internet penetration, these publicly accessible (digital) stories present a potentially effective medium for sharing experience and impacting illness attitudes and perceptions. The results from this in-depth discourse study of authentic cancer stories can inform efforts to utilize narratives and social media for health promotion.

Maria Caiata-Zufferey; Peter J. Schulz

Institute of Communication and Health (ICH) Università della Svizzera Italiana, Switzerland

The Power of Narrative in Chronic Low Back Pain Self-Management

Background and objective of the paper: Self-management of chronic low back pain (thereafter cLBP) requires that patients find their own way to cope with pain, to maintain their life roles and to deal with the emotional consequences of the disease. In this paper we present the behavioral coping strategies that active cLBP sufferers develop in order to handle their health problem. We further explore how participants make sense of pain in a way that orients and supports these strategies.

Methods: In-depth interviews have been conducted with a purposive sample of 18 professionally active cLBP sufferers recruited as part of a program for enhancing and analysing self-management through online communication. Data collection and analysis were driven by grounded theory.

Findings: Successful cLBP self-management is the result of a delicate balance between pain-control and pain-acceptance behavior: people have to switch between observing their body and ignoring it, changing their life and maintaining usual roles, relieving and enduring pain. Behind these behaviors there is a specific way of thinking about pain that makes it simultaneously controllable and acceptable: pain is outlined as rational and informative (thus controllable), and as normal and valuable (thus acceptable). In light of these results, narratives are found to be a central aspect of self-management, as they allow people to make sense of pain in a way that orients and supports efficient coping strategies.

Implications: Health care policy should develop appropriate tools to support cLBP sufferers in developing meaningful narratives oriented to pain self-management.

Amy Sanders; Wen-ying Sylvia Chou

**Health Communication and Informatics Research Branch
National Cancer Institute, USA**

*Reconceptualizing Cancer: A Case Study of Metaphors Used in the
Livestrong Website*

Background & Objective: As communication scholars examine the role of new technologies in health promotion and communication, organizations charged to improve health are using technologies, including social media and video content, to disseminate health messages. Narratives are commonly used in these new media as they have been found to effectively guide individuals in finding meaning and coping with illnesses. This paper aims to analyze the Lance Armstrong Foundation's Livestrong website and describe its effort to reframe cancer through the use of metaphors.

Methods: We conducted a qualitative analysis of 7 embedded videos on the Livestrong website, with a focus on the use of metaphors. Analysis was guided by narrative components outlined in the rhetoric studies of Foss (1996) and Fisher (1992).

Findings: Sporting metaphors are found to be prevalent in the videos, suggesting a new way of reconceptualizing cancer. Contrary to the predominance of war metaphors commonly associated with cancer, sporting metaphors present a potentially more accessible, unifying narrative. Although the two metaphors share common vocabulary surrounding the theme of struggle (e.g. winning, fight, battle), the sporting metaphor attends to the psychological and physical journey with concepts of sportsmanship, teamwork, and sporting events as an empowerment platform.

Conclusion: With the rapid increase of new technologies and social media, narrative-based video communication about cancer will become increasingly prevalent and potentially impact society's conceptualization of cancer. The use of sporting metaphor shows promise as a reframing technique in cancer communication, thriving where the previous use of war metaphor may have fallen short.

Linda Squiers; Suzanne Dolina (presenting author)

RTI International, USA

StoryCorps' Narratives: Disclosing a Cancer Diagnosis

Background: Parents with cancer need to determine how to talk about their diagnosis with their children, yet few feel prepared for this discussion (Turner et al., 2007). Narrative forms of communication (i.e., personal stories) are well-suited for addressing this challenge as research suggests that audiences may view narrative communication as more engaging, realistic, believable, memorable, personal, likely to evoke emotion, and difficult to discount than non-narrative forms of communication (Hinyard & Kreuter, 2007). Little research has been conducted that explores the effects of narratives on cancer patients, particularly with regard to communication about cancer within families. The goal of this project is to develop an educational tool that incorporates narratives from cancer patients and their children gathered via the StoryCorps program (www.storycorps.net) (n=47) in order to help cancer patients tell their children about their diagnosis.

Method: We reviewed the literature to identify key messages for talking to children about a cancer diagnosis and included them in our educational content and coding scheme. We used the coding scheme to identify relevant segments from the narratives. A random sample of narratives was chosen to assess the accuracy of coding.

Findings: Findings that describe four areas of interest will be described: patients' reaction to their diagnosis; preparing for disclosing diagnosis; describing cancer to child; and children's questions.

Implications: Findings will be used to refine the content of the tool which will be tested with cancer patients in Summer 2010. A future study is planned which will assess the effectiveness of a narrative vs. non-narrative version of the tool.

Colloquia E Tuesday June 29th

Decision-Making in Healthcare Settings: A Microethics Perspective

Coordinator: Srikant Sarangi; Ellen Barton

Cardiff University and NTNU (Trondheim)₁, UK; Wayne State University₂, USA

Although ethics and decision-making have remained an ongoing research interest among healthcare researchers with backgrounds in medical professions, ethics, humanities and social sciences, there is a paucity of studies addressing how ethical matters emerge and are managed interactionally by professional practitioners and clients/families in a given communicative setting (Barton in press, Sarangi in press, Sarangi et al in press). The contributors to this colloquium share this situated perspective on ethics, while adopting a broader perspective on what constitutes the 'ethical stuff' (e.g., autonomy, responsibility, moral obligation, trust, informed consent). The papers cover healthcare settings across a number of countries (USA, UK, Norway, The Netherlands) spanning a variety of

disease conditions (e.g., different types of cancer and genetic disorders) and fall broadly into two categories: (i) participation in clinical trials (Barton and Eggly; Sarangi and Davies; Bates, de Bont, van Dulmen, Zwaanswijk and Friele); and (ii) interactions and accounts involving clients and professionals, including interprofessional decision-making (Arribas-Ayllon, Sarangi and Clarke; Kovarsky, Duchan and Walsh; Måseide; Thomassen, Skolbekken and Sarangi). We believe that a microethical perspective that pays close attention to linguistic and interactional features of healthcare encounters and accounts has the potential to make important contributions to the interdisciplinary and interprofessional literature on biomedical ethics.

Michael Arribas-Ayllon; Srikant Sarangi; Angus Clarke

Cardiff University, UK

Professional Accounts of Ethical Dilemmas in the Prenatal Genetics Clinic: The Contingencies of Decision Making

One of the criticisms of principle-based approaches in bioethics is that dilemmas are *translated* into formally rational ends to facilitate calculable and practical decision-making. The problem with this ‘commensurable’ approach is that it tends to reduce rather than engage with the complexity of real life cases. In this paper we examine how ethical dilemmas for genetic professionals are created as much by the universally acclaimed, principle-based approaches to bioethics as they are by clients’ variable expectations when accessing genetic services.

We adopt a situated approach to ethics by integrating rhetorical discourse analysis and accounts analysis in our attempt to examine how professionals, in research interview settings, formulate ethical dilemmas when confronted with clients’ expectations, often bordering on

medical, legal and familial constraints. Our approach unifies two domains of research which are often treated separately: (i) it explores everyday experience, and mundane practical reasoning, as resources for ethical deliberation; and (ii) it explores the role of formulations as rhetorically motivated activities. In a further analysis, we point to how alignments and misalignments between professional and client’s perspectives are managed in terms of implicit/explicit excuses and justifications. Our dataset consists of research interviews involving genetic counsellors, genetic consultants, and paediatricians (n=20) who are discussing difficult cases in the genetic testing of Huntington’s Disease, Cystic Fibrosis, Duchenne Muscular Dystrophy, chromosomal anomalies and translocations.

Dana Kovarsky¹; Judith Duchan²; Irene Walsh³

**University of Rhode Island¹, USA; SUNY at Buffalo², USA;
Trinity College, Dublin, Ireland³**

*The Ethics of Uncomfortable Moments in Speech-Language Therapy
Discourse*

Although there is a high premium placed on the establishment and maintenance of rapport during speech-language therapy, uncomfortable moments do occur when interpersonal relationships are threatened or damaged. In fact, there are times when these moments appear to border on unethical professional conduct, even though this is not the intent of the speech-language pathologist (SLP). In what follows, we will present data gathered from speech-language therapy sessions involving adults with brain injuries that were video recorded and transcribed. A discursive analysis of specific exchanges within these sessions revealed that two aspects of clinical practice contributed to the construction of uncomfortable moments when client autonomy was threatened. They are: the institutional context of intervention, standards for Evidence-Based Practice (EBP) and treatment models included; and the manner in which communication disorders are defined and characterized within the discipline. Together, they both helped facilitate the construction of an interactional substrate of therapy that had unintended negative consequences for clients.

For example, SLPs have traditionally adopted impairment-based models of intervention that focus on fixing intrinsic linguistic deficits. EBP then provides a framework for designing objective and quantifiable measures of treatment effectiveness. While impairment-based models have the advantage of meeting the standards for EBP, they fail to capture the subjective voices of clients. Here, there is little room for using things like personal growth and identity as measures of treatment effectiveness because of their subjective nature that makes them difficult to quantify.

We argue that impairment-based models of intervention can foster an interactional substrate focused on exposing and correcting quantifiable errors of linguistic performance in ways that have the potential to damage identity, limit autonomy and demoralize the client. Transcribed examples will be used to discuss the extent to which these uncomfortable moments constitute actual breeches of ethical conduct, or whether they merely represent awkward instances of clinical interaction.

Per Måseide

Faculty of Social Sciences Bodø University College, Norway

Ethical Issues in Interprofessional Medical Decision Making

This paper derives from a study of interprofessional medical decision making, where moral and ethical issues are invariably implied, if not explicitly stated. The focus is on the practice or pragmatics of ethics as part of collaborative medical problem solving work observed during fieldwork in the thoracic ward of a Norwegian hospital. Essentially much collaborative medical problem solving work is communicatively accomplished. Hence, ethical dimensions of collaborative medical problem solving appear as characteristics of problem solving talk.

Three cases or sequences of talk from institutionalized collaborative medical problem solving work will be analyzed. Each of them displays ethical aspects of medical practice. The first case concerns the question of in whose interest decisions are made. Are they made in

the patient's best interest, the institution's best interest or in the professional practitioners' best interest? The second case regards the interaction order, which is seen as a normative or moral order that characterize sequences of collaborative problem solving talk. It has to do with discursive dominance, discursive tactics and adherence to the norms of the interaction order. The third case shows that turning medical problems into moral problems may be used as a discursive tactic to manage professional and institutional tensions. The cases show the comprehensiveness of ethical issues in collaborative medical decision making. The paper makes no attempt to make ethical judgments, to investigate ethical standards or to distinguish between morally relativist ethics and ethics based on ultimate moral truths.

Srikant Sarangi₁; Donna Davies₂

**Cardiff University₁, UK; Taunton and Somerset NHS
Foundation Trust₂, UK**

*The Nuanced Framing of Clinical Trial Participation in the
Huntington's Disease Management Clinic*

Huntington's Disease (HD) management clinics are attended by patients already affected by the condition, accompanied by their carers. Until recently no interaction-based studies of HD management clinic was undertaken (Davies 2009), although genetic counselling for predictive testing for HD has been studied in detail (Sarangi et al 2004, 2005), including ethical and moral aspects surrounding decisions about testing and disclosure of genetic status (Sarangi et al 2010, Sarangi in press).

The HD management clinic is characterised by (shared) decision making where the carer (either family member or professional carer) speaks on behalf of the patient on matters relating to the medication/treatment regime and lifestyle coping. In this presentation we focus on how the consultant, during assessment of current medication, introduces the topic of clinical trial participation. This activity routinely happens towards the end of the consultation, following physical examination, almost as an aside.

Based on audio-recorded and transcribed data from 12 consultations, our discourse analysis (Roberts and Sarangi 2005, Sarangi, in press) first identifies the key components of this invitation for clinical trial participation (in 5 of the 12 consultations): recruitment procedure, criteria for eligibility, site-specific constraints, benefits and risks, deferral to specialist research nurse for further information etc. Clinical trial, generally speaking, is enshrined in medical uncertainty on the one hand, and professional neutrality on the other. Our analysis focuses on the very uncertainty surrounding participation whether or not the inclusion criteria are met. This uncertainty is further exacerbated by the fact that HD is a debilitating condition whereby patients and their carers have to take on board the practical difficulties associated with clinical trial participation. This becomes a delicate matter which has to be interactionally accomplished, while ensuring that false hope about the benefits of medication or trial participation can be minimised and contained.

**Kiek Tates*, ESJM de Bont², AM van Dulmen¹, M
Zwaanswijk¹, R Friele¹**

**Tilburg University*, the Netherlands; ¹ NIVEL, Netherlands
Institute for Health Services Research, Utrecht, the
Netherlands; ² Department of Paediatric
Oncology/Haematology, University Medical Center
Groningen, the Netherlands**

*Obtaining Informed Consent for Trial Participation in Paediatric
Oncology*

Background: Nearly all children diagnosed with cancer are candidates for clinical research trials. In contrast with adult cancer, there are sharp time constraints on the informed consent process as a result of clinical urgency to start treatment. Therefore, diagnostic consultations in paediatric oncology always include extended dialogues about trial participation, even when the experimental part of the treatment is much later. For parents and children this decision to participate in the clinical trial is complicated: they have to decide on trial participation at a time when they may understand little about the illness trajectory or treatment options. Most research in this area has focused on retrospective parental perceptions of the informed consent process. Little is known, however, about the actual process of obtaining informed consent. This study aims to fill this gap by describing current practices of discussing trial participation during diagnostic consultations.

Methods: In three Dutch university paediatric oncology wards we audio-taped 43 diagnostic consultations of children (mean age 11.9) newly diagnosed with cancer. The data were transcribed verbatim and analysed in terms of turn design, content, and thematic staging, using MAXQDA software for qualitative research.

Findings: The observational data show that diagnostic consultations with parents (dyadic) or with parents and child together (triadic) can be characterized as long monologues with a considerable information overload. In these consultations, there appeared to be no clear distinction between clinical trial information from standard treatment information. In split consultations with child patients, no discussion of trial participation was found.

Implications: Practices of discussing trial participation at the time of diagnosis seem to conflict with ethical goals regarding adequate and valid informed consent.

Gøril Thomassen; John-Arne Skolbekken; Srikant Sarangi

**Institute of Language and Communication, NTNU,
Trondheim, Norway**

Negotiating Parental/Familial Responsibility in the Context of Genetic Testing

Given the familial basis of genetic disorders, in genetic counselling sessions both counsellors and clients routinely orient to others' perspectives, especially in connection with decisions about offer/uptake of genetic testing. Extending Pilnick's (2001) contention that genetic counsellors allude to 'what other people do', Sarangi (2010) has recently proposed a distinction between 'family-others' and 'general-others' vis-à-vis role-responsibility. This provides a basis for our focus in this paper on how parental/familial responsibility is contingently negotiated by/with genetic counsellors.

Responsibility can be viewed as other-orientation in order to capture the dynamic role-relational aspects that clients have to take into account when making decisions, either for themselves or on behalf of other family members (Sarangi, 2010).

Our data consist of 20 genetic counselling sessions within a hospital department of medical genetics in Norway. The clients are either affected by cancer or at high risk of inheriting cancer because of family history. In our fine-grained analysis we demonstrate how 'family-others' and 'general-others' are strategically foregrounded in clinic sessions to inform the decision-making process. We suggest that the role of the genetic counsellor is crucial in keeping the discussions process-driven rather than outcome-driven, while providing necessary information for a sound basis for decision making. Our preliminary findings indicate that counsellors tend to be more directive about the process of decision making (including communication and sharing of information) than about the decisional outcome. We link these findings to the professional ethos of nondirectiveness in genetic counselling.

Colloquia F Tuesday June 29th 11:00-12:30 pm

*Moving Beyond Disparities: Understanding Values and Responsibilities
in Clinical Decision Making*

Coordinator: Karen Lutfey

New England Research Institutes, USA

The purpose of this session is to present new results from a multi-generational, cross-national series of videotaped vignette factorial experiments studying clinical decision making (funded by the US National Institutes of Health, John B. McKinlay, PI). By manipulating design variables to adjust for patient characteristics, physician attributes, healthcare system features, and cognitive processing, the experimental design allows for unconfounded estimates of the relative contribution of each of these factors. Quantitative results show persistent variation in clinical decision by patient characteristics (age, sex, race, and socioeconomic status), provider attributes (gender and level of experience), and healthcare systems (United State, England, and Germany), despite identical presentation of symptoms by actor “patients” in vignettes. Together, these results show how health disparities are due in part to

differences coming from within healthcare systems and not simply as a function of differences among patients—that is, physicians’ decision making may amplify health disparities.

In this colloquium, we use qualitative think aloud data to evaluate the mental reasoning processes underlying aggregate patterns in diagnostic and treatment decisions. With this approach, we have found multiple factors related to decision making that call attention to the value-laden and ethical challenges that are part of medical decision making at the individual, organizational and healthcare system levels. The three empirical papers presented here address some of these themes: how sex and gender are evaluated for patients with coronary heart disease; the dual role of test ordering in physician reasoning; and the ways organizational factors intrude on physicians’ decisions.

Karen Lutfey; John McKinlay

New England Research Institutes, USA

The Urgent Contribution of Qualitative Methods to Health Disparities Research

Background and Objective: Extensive research on health disparities has documented sizeable differences in medical practice variation according to patient characteristics, provider attributes, and healthcare organizations. These results have been replicated for a wide range of conditions and across several countries. For this field to move forward, there is an urgent need to move beyond endless documentation of aggregate patterns and develop an understanding of why these differences occur and the mental reasoning processes that lead to them. Qualitative methods are ideally suited to answer these questions.

Methods: We have conducted a multi-generational series of factorial experiments that combine qualitative and quantitative methods to examine how primary care physicians make clinical decisions for a video vignette patient. The 10-15 minute qualitative think aloud data are recorded in an open-ended format after physicians respond to a series of questions about the clinical actions they would take with the “patient” they viewed. For each of 3

experiments, we have 256-384 think aloud interviews, which we have analyzed using narrative analysis, content thematic analyses, and combined with quantitative data.

Findings: Our results (both published and ongoing) underscore the importance of these kinds of data and methods for moving the field of clinical decision making forward. Specifically, the use of large datasets, cross-national analyses, and qualitative data that are truly integrated with quantitative study design have helped contribute new results that would not be possible without qualitative analyses.

Implications: In this panel, each individual presentation highlights a unique approach, including the ways qualitative methods can be combined with quantitative approaches and in cross-national contexts where quantitative approaches typically dominate. Together these empirical pieces provide examples and discussion points for how to not only sustain but also expand and refine qualitative contributions to health research.

Lisa C. Welch; Matthew Grace; Karen E. Lutfey; John B. McKinlay

New England Research Institutes, USA

Making Gender Visible in Clinical Decision-Making for Coronary Heart Disease

Background and Objective: Persistent gender disparities in CHD diagnosis and treatment are well documented, but the ways in which the social pattern of gender operates in clinical decision-making is not clearly understood. Previous research shows that physicians are less certain about CHD diagnosis for women (Arber et al. 2006), particularly middle-aged women (Maserejian et al. 2009a), and are more likely to discount a CHD diagnosis for younger patients and women (Lutfey et al., forthcoming). Somewhat surprisingly, the gender effect in diagnostic certainty is not explained by reliance on prevalence data (Maserejian et al. 2009b). This paper examines how gender shapes decision-making regarding CHD.

Methods: We analyze qualitative data from 253 primary care physicians who participated in a video vignette-based factorial experiment. The design held constant the presentation of CHD symptoms in order to isolate patient and

physician characteristics that impact decision-making. We utilize narrative and theme analyses to identify differences by patient gender.

Findings: Preliminary findings show that, despite the same presentation of symptoms across vignettes, physicians tend to describe symptoms as “atypical” when the patient is a woman and are more likely to consider a mood-related diagnosis for women than men. Both viewing symptoms as “atypical” and considering additional diagnostic possibilities may lead to lower diagnostic certainty.

Implications: Making visible the ways in which gender shapes (even if unconsciously) physicians’ interpretations of symptoms is important because only when physicians are aware of how gender currently operates can they work toward counteracting the interactional “scripts” that contribute to disparities.

Jonathan Tritter₁; Karen Lutfey₂

University of Warwick₁, UK; New England Research Institutes₂,
USA

*What are Tests for? The Consequences of Certainty and Pre-Approval
for Doctors and Patients*

Background and objective: Previous work has established that doctors in England and the US respond to patients presenting with the same symptoms differently in terms of diagnostic testing, advice and prescribing (Knesebeck et al., 2008; Mckinlay et al.). This paper extends this and subsequent work (Lutfey et al., 2008) by considering ways that diagnostic certainty has consequences for decisions to order further investigation. We seek to explore the reason and consequences of the ordering of diagnostic tests and how these are influenced by reimbursement policies and clinical governance mechanisms in the United States. Further, we explore the impact on the patient pathway of the constraints on clinical autonomy. Finally we consider the implications of such findings for approaches to clinical governance in other health systems and health reform in the United States.

Methods: Data are based on videotaped patients within an experimental study design. 256 randomly selected family physicians in the United States were shown the videotapes of experienced actors playing the role of patients with coronary heart disease. After watching the video vignette physicians were asked how they would diagnose and manage the patients they had seen and how certain they were of their diagnosis. The present analyses are based on qualitative think aloud data about physicians' reasoning processes for the vignette case.

Findings: Our findings suggest that

consider trustworthy evidence and what they would "hang their hats on". However, those physicians who were more certain about their diagnosis were more likely to suggest the need for further diagnostic testing. Many of the diagnostic tests that they would prefer to order require pre-approval from an insurer and this has consequences. This requirement leads to a 'stutter-step' in the patient's pathway as they are forced to wait for the approval which may entail a further appointment prior to the test itself. Such 'stutter-steps' may be repeated if patients are referred to another physician or practice which may repeat diagnostic tests as results are often considered proprietary. The issue of pre-approval also emerge in relation to decisions about treatment. Our findings suggest that while some prescription software may mitigate some of these difficulties the burden of reimbursement policies is felt by both physicians and patients.

Implications: The motivation for diagnostic testing is unclear but is not explained by the desire to increase a physician's certainty of a diagnosis. Rather, testing may relate to the need to safeguard a decision against potential litigation, the desire to generate 'scientific' evidence to complement the art of diagnosis (Eddy and Clanton 1982), or simply to generate extra income. The lack of consistent definitions of what counts as legitimate evidence and the new restrictions on medicare payments for diagnostic tests may lead to delays and challenges to the certainty of a diagnosis

Courtney Jackson; Rebecca Shackelton; Lisa Marceau; John McKinlay

New England Research Institutes, USA

Ethical Implications of Intrusions into the Doctor-Patient Relationship

Background and objectives: The doctor-patient relationship has traditionally been viewed as a dyadic, closed-system encounter between just two parties. Increasingly, however, various interests have been intruding on the encounter and now shape clinical decision making. This paper explores the ethical implications of one form of external intrusion- the health insurance sector - into the doctor-patient relationship.

Methods: Data come from a semi-structured interview portion of a vignette factorial experiment, including 178 primary care physicians in NY, NJ, and PA. Physicians answered open-ended questions about their treatment goals for the patient featured in the vignette, the anticipated challenges, and predictions of outcome.

Findings: Physicians expressed concerns about the intrusion of health insurance imperatives: 1) pre-approvals increase costs by dictating “needless” steps before approving what the physician initially proposed to do; 2) formularies

contradict guidelines, compelling less optimal treatments; 3) insurance industry staff, with little clinical experience, challenge physician authority. Physicians in our study adopted one of five types of response to these external intrusions: 1) Defiance – a few stopped accepting restrictive plans; 2) Gaming the system – some physicians described seeing patients more frequently; 3) Adaptation – some physicians created new practice infrastructure; 4) Resignation – physicians described accepting lower pay and/or greater interference; 5) Retreat – some physicians expressed concern about doctors choosing other specialties or leaving medicine all together.

Implications: External forces erode trust and raise questions about whose interests physicians serve. This paper provides new qualitative evidence to enhance our understanding of the ethical dilemmas physicians face in their clinical work with patients.

John McKinlay

New England Research Institutes

Discussion: Ending the Reign of Error: Time for a Sociological Surge in Decision Making Research

Colloquia G Tuesday June 29th 1:30 pm- 3:00 pm

Presence in Health Care Communication - Discursive and Ethical Dimensions

Coordinator: Ulla Hellstrom Muhli

Discussant: Michael C. Brannigan, Department of Philosophy & Religious Studies, The College of Saint Rose, USA

The aim of the colloquium is to discuss communicative challenges in health care settings from the perspective of the ethical dimension of 'presence'. Presence is understood as 'being-there', 'being-with', 'being-for', 'being-in-relation' and 'being-in-transcendence' (Brannigan, 2009). Of particular interest are the communicative practices and the professional development of presence in encounters with clients, specifically when listening to rather than questioning them.

Language and ethical communication play a significant role in many settings e.g. in care assessments, consultations, delivering difficult information. Four researchers from different disciplines, sociolinguistics, caring science, education and communication, who share a common interest in ethical communication, present research illustrating various facets of presence in health care settings. For example, how to manage the risks and consequences when presence is not established in patient/doctor consultations; how an

ethical, individual-centered communication within a bureaucratic institutional caring context can mediate presence; the relevance and role of presence in the quality of health care delivery. If presence is considered as an essential element of 'being-in-relation' in health care interaction, how does this distinguish 'interaction' from 'meaningful interaction'? Attempts to address these questions will be presented and discussed.

Our results can stimulate discussion around:

- The bridges between ethics and communication
- Communication is an ethical enterprise as much as ethics is a communication enterprise
- The principle-based ethics and situated ethics
- Ethics and moral responsibility
- Health care as moral (dis)order
- Situated communicative practices as embodying ethical/moral dimensions
- Awareness of presence as a property of quality health care

Jill Dales

**School of Medical Sciences Education Development, The
Medical School, Newcastle University, UK**

Presence in a Doctor/Patient Consultation

Background: This paper explores the concept of presence in a doctor/patient consultation and potential consequences when presence is not established. It is taken from an ongoing ethnographic PhD study looking at what influences a doctor's communication with a new patient.

Methods: A staged approach was used to capture key aspects of the communication process: cognitive interviewing of the doctor during their first sight of referral information about the patient to explore the 'anticipated communication'; observation of the consultation to identify the 'actual communication'; semi-structured interviews with the doctor post-consultation to explore both the 'anticipated' and 'actual' communication. A purposive sample of 9 consultants from one specialty was recruited from one acute NHS Trust. Analysis is iterative.

Findings: This paper draws on interviews with one consultant and involving one patient. In this clinical encounter, the doctor persuaded the patient to undergo an invasive procedure, despite, prior to seeing the patient, insisting that such an investigation was not medically necessary and that during the consultation, the patient expressed they did not want it. The doctor's explanation for this was that he had failed to 'connect' with and hadn't really liked the patient.

Implications: Implications are for further research of the significance of 'presence' and possible consequences when 'presence' between a doctor and patient is not established. It raises the issues of consent being obtained based on how a doctor feels about a patient and has implications for medical training in communication skills, ethics and decision making.

José Carlos Gonçalves

**Universidade Federal Fluminense, Leblon Rio de Janeiro,
Brazil**

A Continuum of Presence in Health Care Communication

Background: This paper draws from a micro-ethnographic research of patients' narratives and professionals' renditions, tape-recorded consultations and interviews with doctors and other health professionals. It focuses on the characterization of presence and its role and relevance in the delivery of quality health care to the patients.

Methods: Presence in doctor-patient interactions is approached from an interactional sociolinguistic perspective as a continuum of verbal and non-verbal features which may determine plus or more presence, rather than a dichotomous presence-non-presence phenomenon. Interactants in health care settings are dynamic contexts to one another. Presence indexes can be linguistic, non-linguistic and/or paralinguistic interactional features such as alignments and footing, contextual clues, and other kinetic, proxemic and paralinguistic markers.

Findings: Results show a clash of frames

and interactional expectations. While doctors objectify the interview, patients subjectify the encounter. Doctors approach the interview as a task. Patients expect a personalized attention. Doctors' presence is more a physical being-there and being-for, than being-with. Being-in-relation and Being-in-transcendence (Brannigan 2009) are far from reach in the data analyzed.

Implications: Jointly re-framing the interview is a way to eliminate the clash of objectification and subjectification frames. By developing an ear for contextualization clues and listening to learn, rather than to question, professionals may develop attentive listening. By accommodating their strategies towards the patient, professionals may create solidarity, show affect, empathy, signal a sincere concern with patients' well being and create the necessary rapport for the successful outcome of the task and interactional satisfaction of participants.

Roxana Delbene

Department of Arts and Languages, Alvernia University, USA

From Interaction to Meaningful Interaction in Medical Communication: A Study of Presence in the Screenplay Wit

Background: Discourse-based studies within sociolinguistics, conversation analysis, and (critical) discourse analysis traditions have focused on the study of interaction, especially as shaped by institutional constraints (e.g., Drew and Heritage 1992, Heritage and Maynard 2006, Sarangi and Roberts 1999). These traditions have made significant insights in medical communication, but little attention is paid to the analysis of what constitutes a meaningful interaction. Traditionally, this concern has been addressed by philosophers (e.g., Sulmasy 2006a and b). I explore the discursive boundaries between interaction and meaningful interaction in the screenplay *Wit* (2001). A meaningful interaction is defined as the building of a relationship, even a short-term relationship. Presence is considered an essential element of being-in-relation (Brannigan 2009). Gardner (1985), Liehr (1989), Suchman (1988) agree that presence requires reciprocity, sense of connection, and mindfulness. Yet, these characteristics have not been coded in discursive terms.

Methods: Activity analysis (e.g., Levinson 1979, Sarangi 2000, Gumperz 1982) was used in mapping the rhetorical, interactional, and thematic trajectories of (non) meaningful interactions.

Findings: The physicians seemed to observe bedside manners (Fletcher 2007) with her patient (Emma Thompson) as dictated by the professional order, but paradoxically these manners are empty since they are conveyed in misalignment and out of context. Conventionality and speakers' communicative intentions are in dissonance.

Implications: In *Wit*, the dilemma of absence of meaningful interactions is artistically and purposely represented. For this reason, it can be mapped with pedagogical purposes. The microanalysis used in discourse studies is expected to complement the philosophical approach to presence.

Ulla Hellström Muhli

School of Life Sciences, University of Skövde, Sweden

The Ethical Dimension of Presence in Elderly Care Talk-Encounters

Background: Ethical, individual-centered communication in elderly care is respectful of and responsive to a person's needs, beliefs, values, preferences and to the dimension of presence. However, in talk-encounters between care managers and elderly clients, the dialogues are framed by a bureaucratic order and not by the ethical dimension of presence. The significance of this ethical dimension within relationships and in the talk-encounters have not previously been considered.

Aim: To explore the ethical dimension of presence in talk-encounters between care managers and elderly clients and explore how the institutional context influences the ethical dimension and how it was discussed, perceived and approached by the professionals involved.

Methods: The core element in the presence is understood as "being-there" and different dimensions of presence were observed and analyzed in interactions between elderly clients and care managers. The dialogues between the parties were recorded, transcribed verbatim and translated. An activity analysis of institutional settings and categorization of the presence was made.

Findings: I am making two major points about ways of being there in need assessment dialogues. Firstly, how the degrees of intensity in the context of 'another' serves the purpose of presence. Secondly, how individual-centered communication is the key to high-quality elderly care.

Implications: Knowledge about presence contributes crucially to the ethical quality in talk-encounters in elderly care. Furthermore how these dialogues can be client-oriented and pedagogical.

Colloquia

Invited Colloquia Tuesday June 29th 1:30-3:00 pm

State of the Art Communication Research in the US Department of Veterans Affairs

Coordinator: Barbara Bokhour

The United States Department of Veterans Affairs Healthcare System (VHA) is the single largest integrated healthcare system in the US, funded by the federal government to provide healthcare services to veterans of the US armed forces in 171 medical centers. Part of the mission of the VA is to conduct research that “aspires to discover knowledge, develop VHA researchers and health care leaders, and create innovations that advance health care for our veterans and the nation.” The Health Services Research & Development (HSR&D) division of VHA research is dedicated to identifying the best practices for providing high quality healthcare to our nations’ veterans. Patient-provider communication is a critical aspect of high quality health services, and subsequently many studies in VA focus on some aspect of communication. This invited colloquium

(funded by VHA HSR&D), showcases the different types of communication research going on within the VHA. Dr. Rich Frankel will present on the use of qualitative research methods for examining and improving on communication with veterans. Dr. Som Saha will present his work on the role of communication and patient-provider relationships in racial/ethnic disparities in the quality of healthcare. He will discuss his development of methods to measure cultural competence and efforts to reduce racial barriers in the patient-provider relationship. Finally, Dr. Charlene Pope will present on the wide range of nursing research in VHA health communication and potential avenues for disparities research yet to be developed. These papers will provide a broad overview of some of the communication research being conducted in the VA.

Richard M. Frankel

Indiana University School of Medicine, USA

The Qualities of Qualitative Research in the Veterans Affairs Healthcare System

In one of its most widely cited and influential reports, the Institute of Medicine, asserted in 2001 that patient-centered care (PCC) was one of six domains of quality in medical care, the others being safety, effectiveness, timeliness, efficiency, and equity. Although all of these domains involve forms of communication and meaning-making it is in the patient-centered care arena that qualitative research has emerged as a core methodological approach. A growing body of qualitative and multi- method research has demonstrated that the presence of PCC results in better biomedical and functional outcomes of care, improved satisfaction, trust, reduced risk of medical malpractice and adherence to medical recommendations. In addition, qualitative descriptive studies of care processes such as “handoffs,” use of

electronic medical records in the exam room, and communication about high alert medications are identifying opportunities for education and improvement within the VA system.

My presentation will focus first on a broad overview of qualitative research methods and where they are appropriate to use in the development and management of knowledge. Next I will present 2-3 brief case studies where qualitative research approaches are currently being used to address gaps in care currently being experienced in the VA. Finally, I will focus on recommendations for developing a “roadmap” for the future of qualitative research in the VA and identify some “targets of opportunity” that could help shape HSR&D’s research portfolio in the next 3-5 years.

Charlene Pope

Ralph H. Johnson Veterans Affairs Medical Center, USA

The Veterans Affairs Role in Broadening Approaches to Communication Research for Nursing

The uniquely multidisciplinary construction of health service research in the VA promotes communication research by nurses in ways less evident in other institutions in the US. Over 25 years ago, Kasch reviewed nursing communication research and identified the predominant approaches shaped by the concept of competence, a discourse that views communication as intentional, instrumental, regulative, relational, and engaged in identity management, roles meant to accomplish tasks and insure compliance. This presentation will review how subsequent nursing communication research has evolved in the VA from this earlier largely functional agenda and its potential role in health disparities research.

An integrative literature review will demonstrate the limitations of traditional nursing research in the identification of social identities and social positioning in talk, with consequences to nursing's possible role

in disparities research. Examples from current nursing research in progress within the VA system will illustrate the diversity of communication research approaches, methodologies, and their study of differences in the process and outcomes of health services. VA resources and its openness to the frank examination of the process of care currently supports nurses involved or proposing studies of the quality of telehealth services, narratives of incarceration, racial variations in provider-patient encounters, interprofessional communication, multilingual educational materials, care of the elderly, medication management, and workplace bullying. Consequently, VA nursing participation in multidisciplinary mixed methods communication research moves beyond the constraints of what was said to link how participants speak with one another and consider social contexts with consequent effects on Veteran outcomes.

Somnath Saha

Portland Veterans Affairs Medical Center, OHSU, USA

Addressing Racial Barriers in Patient-Provider Interactions in Veterans Affairs Primary Care

Studies have clearly demonstrated that racial disparities in the quality and quantity of health care exist within the VA health care system, despite relatively equal financial access for all veterans. A systematic review of the VA disparities literature indicated that barriers between patients and providers might contribute to differential care by patient race and ethnicity. These barriers include patient distrust and skepticism, differences in communication and culture, racial bias and stereotyping, and other factors contributing to suboptimal patient-provider partnership.

Cultural competence (CC) training has been the health professions' principal response to addressing racial barriers in the patient-provider relationship and their potential contribution to health care disparities. It has been difficult to determine whether CC training has been

effective due to the lack of: 1) standard definitions of what constitutes provider CC; 2) well-developed instruments to measure provider CC; and 3) an empirical evidence base informing the appropriate content of CC training. In this presentation, we will describe our approach to developing an evidence base to inform efforts to reduce racial barriers in the patient-provider relationship. We will begin by describing a qualitative literature review that resulted in a composite conceptual framework of CC dimensions. We will then review results of the initial validation of a survey instrument measuring provider CC. Finally, we will describe the conceptual model and methods of a VA-based study that will examine the contribution of patient-provider racial barriers to disparities in diabetes care, and the role of provider CC in mitigating this contribution.

ORAL PRESENTATIONS

Ann Adams₁; Christopher Buckingham₂; Laura Vail₁; Eleanor Gilbert₁

**Health Sciences Research Institute, University of Warwick₁,
UK; Aston University₂, UK**

*Empowering Patients and Clinicians to Communicate About Risks
Associated With Mental Health Problems*

Background: Detecting risk associated with mental health problems is every clinician's business, yet communicating about risk is difficult for both patients and clinicians. Risk assessment and communication is hampered by lack of awareness, knowledge, expertise, different perceptions of risk and a lack of appropriate language with which to communicate difficult concepts, thoughts and feelings. There are also difficulties surrounding how risk information is recorded and shared between clinicians and services. The Galatean Risk Screening Tool (GRiST) is a web-based decision support system modelled on how expert clinicians assess the risks of suicide, self-harm, harm to others, self-neglect and vulnerability (see www.galassify.org/grist). Its aim is to disseminate this expertise to those who do not have it, but who encounter people with mental health problems, and to provide a common risk language.

Method: This paper describes how a companion service user version, GRiST-SU, has been developed through a series of semi-structured interviews and iterative focus groups with mental health service users. The aim of GRiST-SU is to assist self-assessment and self-management of risk, and to improve clinician-patient communication about risk.

Findings: were used to validate the risk model underlying GRiST, and provided information about the appropriate language, interface and functional requirements for GRiST-SU, which will be demonstrated.

Implications: GRiST-SU represents a unique and important resource for helping patients and clinicians to assess and communicate more effectively about risks associated with mental health problems.

Jon Allard; Alan Bleakley

Peninsula College of Medicine & Dentistry, UK

The Micropolitics of Clinical Teamworking

Background/objective: ‘Micropolitics’ is a term used to describe power relationships within small group settings. The focus of this study is the clinical team. The research is focused on multi-professional clinical teams working in two distinct healthcare settings: an emergency department in a large general hospital and an acute psychiatric ward in a mental health hospital.

The study aim is to understand how shared decisions are made, how this process is affected by power and what practitioners do to overcome or sustain micropolitical barriers.

Data and method: The research methodology involves two in-depth qualitative ethnographic case studies. A mixed methodology approach (naturalistic unobtrusive observation supported by semi-structured interview and video recording of live teamwork) enables clarification of findings by identifying different ways phenomenon is being seen.

Findings: Multi-professional teams use unique techniques in local clinical settings to overcome micropolitical barriers. Shared decision making is affected by historical power dynamics related to hierarchy and professional boundaries as well as local meso (organisational concerns and management systems) and wider macro (governmental) pressures. Teams must negotiate these barriers as they make ethical decisions related to patient care.

Communication techniques are illustrated through presentation of video recordings of live multi-professional practice.

Implications: The delivery of patient care has changed considerably over the past 20 years. Pressure for efficiency has led to increased role merging and erosion of professional boundaries. This study illustrates how teams are adapting to changes in power dynamics as they make complex decisions. It highlights techniques for safe, ethical clinical practice.

Eleonor Antelius,¹; Lars-Christer Hydén

Linköping University, Sweden

*Communicative Disability and Stories: Towards an Embodied
Conception of Narratives*

Background/objective: Persons with communicative disabilities are often involved in storytelling that does not necessarily conform to the conventional expectations of what constitutes a narrative. Yet, narrative analytic tradition has often taken the written story as a 'paradigmatic example' of a narrative. How then, could we think about, and analyze stories, when the storyteller has impairments that affect his or hers ability to tell stories in interaction with others?

Data and method: The study is based on empirical cases that highlight the ways that storytellers actively use the storytelling situation creatively, including conversational data gathered at a day centre for people with severe brain damage as well as 'typical examples' often found in (narrative) literature.

Findings: By analyzing the relationship between story and storytelling event, and the relationship between different storytellers, we show that storytellers with communicative disabilities are often quite inventive in presenting themselves through other means than vocally animating a coherent, structured story. This however, only becomes evident if we recognise that the telling of and listening to stories should be regarded as an embodied activity and that it is through the process of embodied storytelling and listening it becomes possible to realize that some stories are told by bodies that differ from the norm.

Implications: To be able to study stories told by persons living with severe communicative disorders not only the concept of narratives need to be re-defined, but also the methods used – studies should take place in context leaving narratives methods best used if combined with ethnographic methods.

Meagan Araujo

The University of South Florida, USA

The Move Towards Standardized Medical Language and Its Implications For Patients And Healthcare Providers

Background: In cooperation with the World Health Organization (WHO), The Mayo Clinic is leading a global effort to standardize the language of disease and medical condition, claiming that such standardization will benefit patient care around the world. According to The World Health Organization, the move to standardize medical language will improve communication and benefit patients.

Methods: To contextualize and analyze this argument, I first look to the airline industry as a model of standardized communication. In the airline industry, as in healthcare, there is, according to this push for standardization, a hierarchy of privileged discourse. Then, drawing on examples from other language debates including language policies, bilingual education, institutional discourse in the work place, and specifically medical discourse, I examine the move towards standardizing medical language in clinical settings and the implications

such standardization could have on patient-provider interaction.

Findings: I argue that the standardization of medical language could have serious, negative consequences for social interaction within the context of health communication. Theoretically, this paper highlights the need to pay attention to structure and participation in specific social situations as they tell us something about the relationship between to people and the authority they exercise through talk and interaction.

Implications: The implications of the move towards language standardization in clinical settings extend beyond physicians, mid-level practitioners, and nurses to medical interpreters around the globe. I focus specifically on the role of the medical interpreter and offer interview transcripts to show how the role of the medical interpreter might be impacted by language standardization.

Elma Avdi; Ilana Rischin

Centre for Language Programs Holmesglen, Australia

The Influence of Language and Culture on Medical Student Interviews

An important finding from our previous study, "Empathic communication skills in medical student interviews" (Avdi, Barson & Rischin, 2008), is that first year medical students from culturally and linguistically diverse (CALD) backgrounds appear to be limited in their ability to express empathy with simulated patients (trained actors taking on the roles of patients). This finding was reached by applying the Model of Empathic Communication (MEC) (Suchman, Markakis, Beckman and Frankel, 1997) to interviews between medical students and simulated patients.

The current study offers an educational intervention for teaching empathic communication skills to all students, regardless of cultural and linguistic background. 44 students focused on improving their empathic communication skills in 3 x 1.5 hour

communications skills tutorials . A discourse analysis of the transcripts and videotaped performances of local and CALD students, before and after teaching interventions, was carried out to discern whether there were any differences in the quality of the performances.

Overall, the performances of most medical students in the simulated interviews improved from pre- to post-teaching intervention. However, CALD students gave 'limited empathic responses' more frequently than their local student counterparts.

More research is required, but if CALD students have a particular style of responding to patient emotion, and if this style is due to cultural and linguistic factors, then targeted cross-cultural training is recommended.

Mariaelena Bartesaghi; Annette Christy

University of South Florida, USA

The Baker Act's Revolving Door: Provider's Accounts, Membership Categories, and the Management of Moral Accountability

Background/objective: The Baker Act is Florida's involuntary treatment statute. It provides for emergency mental health examinations of up to 72 hours in designated facilities in case of harm to self, others, or self neglect. The phrase "the revolving door" has been coined by the mental health sector to identify problematic patients; revolving door patients are poor, cycle in and out of emergency inpatient care, and take up valuable resources. At the same time, these patients reveal the complexities and systemic limitations of the Baker Act, as well as its enmeshment with issues of substance abuse, for which it is not designed. This paper investigates how mental health providers account for the revolving door problem in their everyday experiences with the Baker Act.

Data & Methods: Using a blend of discourse analysis and membership categorization analysis (MCA), we

analyze interviews (recorded and transcribed at an intermediate level of detail) with sixteen staff members of Baker Act receiving facilities from 5 Florida counties.

Findings: We show how staff accounts of Baker Act use and abuse involves moral categorization of patients and community (what they should and should not do, their responsibilities, issues of blame), as well as reflexive constructions of staff as moral agents, that have surprisingly little to do with the Baker Act itself and much to do with upholding traditional accounts of psychiatry and mental illness.

Implications: This study adds to the literature on psychiatric discourse as a form of moral accounting, and sheds light on how the discourse of legislative change may in fact reveal as much as it conceals.

**Mary Catherine Beach; Carlton Haywood; Mark Hughes;
Rochelle Brown; Michele Massa; Neda Ratanawongsa;
Lanzkron Sophie**

Johns Hopkins University¹, USA

*Improving Clinician Attitudes toward Patients with Sickle Cell Disease:
The Impact of a Film Intervention*

Background/objective: Clinician attitudes are associated with patient-physician communication and patient outcomes. Yet attitudes are considered difficult to change, and few interventions have attempted to do so. We tested the effect of a film intervention to improve clinician attitudes toward patients with sickle cell disease (SCD).

Data and method: We developed an 8-minute documentary film depicting adults with SCD, their families, and clinician experts discussing the challenges SCD patients face in seeking pain treatment. We developed the following measures: an 8-item Index of Drug-seeking Behaviors which assessed views on whether certain SCD patient behaviors are signs of inappropriate drug seeking (range 0 – 8); a 7-item Positive Attitudes Toward SCD Patients scale (range 7 - 38; Cronbach's alpha 0.87); and an 8-item Negative Attitudes Toward SCD Patients scale (range 8 - 43; Cronbach's alpha 0.85). Physicians

and nurses were randomly assigned to complete the questionnaires before (control) or after (intervention) viewing our SCD film.

Findings: 276 clinicians participated; most were female (87%) and white (54%). Compared to controls, intervention clinicians attributed fewer SCD patient behaviors to drug-seeking (4.4 vs. 5.0, $p=0.034$), and expressed more positive (23.8 vs. 22, $p=0.013$) and less negative (19.4 vs. 21.9, $p=0.001$) attitudes toward SCD patients. Most pronounced changes were physician estimates of SCD patients likelihood of exaggerating pain (43% control vs. 29% intervention, $p=0.008$) and being manipulative (56% vs. 37%, $p=0.003$).

Implications: Clinician attitudes toward SCD patients may be positively influenced through a brief intervention. Further research will explore if attitudinal changes are sustainable or linked to clinical outcomes.

**Mary Catherine Beach¹; Somnath Saha; P.Todd Korthius;
Victoria Sharp; Jonathon Cohn; Richard Moore**

Johns Hopkins University¹, USA

*Communication Measures and Patient Satisfaction: Are Associations
Similar Across Ethnic Groups?*

Background/objective: Patient-centered communication is that in which the patient is given enough time, participates actively, enjoys mutual rapport, and addresses psychosocial issues. We conducted this study to examine whether patient satisfaction is associated with these particular patient-centered communication measures, and whether these associations are similar across different racial/ethnic groups in the United States.

Data and method: We audio recorded 45 providers with 420 HIV-infected patients, and analyzed recordings with the Roter Interaction Analysis System (RIAS). We used negative binomial regression to evaluate if patient satisfaction is associated with total visit length, ratio of provider:patient talk (verbal dominance), rapport-building, and ratio of psychosocial:biomedical talk. We conducted all analyses on the total sample and then explored potential interactions with patient race/ethnicity. All analyses adjust for study site,

clustering of patients within providers, and potentially-confounding covariables.

Findings: Providers were mostly white (69%) and Asian (24%); 57% were women. Patients were African American (58%), white (25%) and Hispanic/Latino (15%); 34% were women. In adjusted analyses, patients with higher vs. lower satisfaction had visits with less provider verbal dominance (1.37 vs. 1.51, $p=0.003$). There was no association between patient satisfaction and visit length, rapport-building, or ratio of psychosocial:biomedical talk. These results were found consistently across all racial/ethnic groups.

Implications: Patient satisfaction is related to less provider verbal dominance; this is seen consistently across all racial/ethnic groups in the United States. Patient satisfaction is not associated with other measures of patient-centered communication.

Emily Bower

Veterans Affairs Boston Health Care System, USA

Communication about the End-of-Life: Medical Students' Attitudes and Preparation

Background/objective: Physicians in many medical specialties are called upon to discuss end-of-life (EOL) issues with their patients. An effective discussion involves complex communication skills. For example, it is necessary to integrate principles in shared decision making with patients' values and preferences. Moreover, it is important for clinicians to have insight into their own attitudes about EOL care, gaps in knowledge, and the ability to improve skills deficits. However, physicians receive little training in these competencies (Sullivan, Lakoma, & Block, 2003). To improve medical training curricula, first it is important to characterize the current medical school experience.

Data and method: Medical students at the West Virginia University School of Medicine (n = 169) completed measures about EOL care, including the students' self-rated preparation to communicate about care, attitudes, knowledge, learning experiences, and perception of a "hidden curriculum" or informal

messages about the training value of caring for dying patients.

Findings: Results indicated that educational experiences (e.g., didactics and perceived hidden curriculum) predicted students' self-rated preparation. Further, knowledge of EOL care predicted attitudes. In particular, students with greater knowledge endorsed more positive attitudes.

Implications: The present study indicated that formal education in EOL communication has a significant role in the development of medical students' positive attitudes and self-rated preparation to communicate about EOL issues. Data further affirm the importance of examining the influence of informal education more closely. Clarifications about these relations could inform the revision of training curricula, and ultimately, promote higher quality communication between physicians and their patients.

Wan-ting Chang

National Cheng Kong University, Taiwan

*Making Open Questions Work: Towards Patient-centered
Communication*

How to ask an open question in medical encounters is significant since it helps doctors to collect a full perspective of patient problems and thus make a more appropriate diagnosis and treatment plan. Given its significance, this paper examines the talk among doctors, patients, and patients' companions ('the patient parties' hereafter) from two aspects: doctors' strategies in initiating open questions and patient responses. By examining two medical encounters collected at a teaching hospital in southern Taiwan, I will present evidences to demonstrate two types of medical interviews observed in Taiwan: biophysical-oriented and psychosocial-oriented interview styles. Following Tsai (2006), I group doctors' open questions into three categories: general (e.g. 'why are you here today?'), biophysical (e.g. 'what symptoms do you have?') and psychosocial open questions (e.g. 'do

you feel anxious recently?'). In the analysis, biophysical open questions refers to question whose literal meaning focus only on the biophysical problems that patients have (e.g. 'I have a serious headache' to 'what symptoms do you have?'). However, general or psychosocial open questions led to more psychosocial-oriented correspondences (e.g. 'I didn't sleep well last night' to 'why are you here today?'). From patients' responses, it is found that different uses of open questions are as operative strategies to elicit patients' main concerns, towards patient-centered communication. The implication of my research is beneficial for medical professionals to improve health status and increase efficiency of care.

Kurt Christensen; J. Scott Roberts; Wendy Uhlmann; Peter Whitehouse; Charmaine Royal; Thomas Obisesan; L. Adrienne Cupples; Robert Green

University of Michigan School of Public Health, USA

Perceived Personal Utility of Alzheimer's Disease Genetic Susceptibility Testing and Its Influence On Post-Test Responses: Findings From The REVEAL Study

Background: Predictive APOE genetic testing for Alzheimer's disease (AD) is not part of standard medical practice due to a lack of proven AD prevention options. Whether testing has personal utility, such as informing long-term plans and providing insight about children's risks, is unclear.

Methods: In the second round of the REVEAL Study, a multi-center randomized clinical trial, 280 first degree relatives (FDRs) of AD patients indicated their reasons for seeking testing prior to receiving an AD risk assessment based on APOE genotype, family history, ethnicity and gender (risk range: 13-77%). Twelve months after results disclosure, subjects self-reported on personal utility outcomes of interest. Logistic regression examined whether primary reasons for seeking testing or test results affected post-test outcomes.

Findings: Reasons endorsed as very or extremely important for seeking testing

included the need to make arrangements for long-term care (64%) and the need to arrange personal affairs (64%). Subjects with the risk-increasing allele more often changed retirement plans (OR=4.2), long-term care insurance (OR=2.4), and health behaviors (OR=1.7) than those without the allele. Subjects who sought testing primarily to arrange personal affairs more often modified retirement plans (OR=4.0) than those who didn't, and subjects who sought testing primarily for information on preventative measures more often modified health behaviors (OR=1.9) than those who didn't.

Implications: Many FDRs of AD patients perceive personal utility in AD genetic risk assessments, and those perceptions affect risk assessments are used. Findings suggest that personal utility may be important to incorporate when considering policies about APOE genetic testing.

**Felix Chukwuneke; Nnamdi Onyire; Odidika Umeora;
Thecla Ezeonu (presenter)**

University of Nigeria Teaching Hospital Enugu, Nigeria

Culture and Biomedical Care in Africa: The Influence of Culture on Biomedical Care in a Traditional African Society, Nigeria, West Africa

Biomedical Care in Africa and the influence of culture on the health-seeking behaviour of Africans can not be underestimated; many African cultures have different understanding of the causes of disease which more often affect our public health system, policy, planning and implementations. Most people believe diseases are caused by supernatural beings, the handiwork of neighbours or vengeance from an offended god as a result of transgressions committed in the past by an individual or parents. Unlike a doctor trained in western biomedicine, the traditional African healer looks for the cause of the patient's ailments as misfortune in relationship between the patient and the social, natural and spiritual environments. The complexity of African society with different cultural and religious practices also reflects on the people's attitude and understanding of their health matters. The extended family values are still the norm and in fact remain the backbone of the social system among Africans. Family relationships are guided by hierarchy and seniority. Individuals turn to

members of the extended family for financial aid and guidance, and the family is expected to provide for the welfare of every member in time of ill health. Therefore, an individual that benefited from the family structure is expected to owe allegiance to the system in return and in certain situations, do not have autonomy to decide on his or her health matters without the family input. Consequently, there is underutilization of health care services at the primary level because most people do not accept the model of health care system provided for them. This group of people therefore prefers seeking traditional medicine to seeking orthodox medicine and often ends up in the hands of witch doctors who claim to have cure to almost all the diseases including HIV/AIDS, VVF, TB and the rest. There is need therefore to focus on health outreach programmes and enlightenment campaign in Africa especially in the rural areas that are more vulnerable and are burdened with many of these diseases. This paper is an overview of the cultural influence on biomedical care in a traditional African society, Nigeria, West Africa.

Rosemary Clerehan; Rachelle Buchbinder

Monash University, Australia

Research into Practice: Nuancing Identities of Providers and Patients

Translating results of applied linguistic healthcare communication research into healthcare practice requires a finessing of processes and procedures, negotiation of identities, and acceptance of tensions between bodies of knowledge. A tool we developed, the Evaluative Linguistic Framework (ELF), was trialled on participants with rheumatoid arthritis (RA), and their assessments of the leaflets they viewed aligned with the framework in terms of what constituted a 'good' leaflet. While the main purpose of the leaflets they identified as being information provision, participants also wanted clear instructions, responsibilities outlined, benefits highlighted and side effects to be comprehensively listed. As planned, we then reported our findings to the Australian Rheumatology Association and Arthritis Australia so they could use them to update their Medicine Information Sheets. Our input consisted

of our annotations on the current online versions of the leaflets, together with a list of recommendations drawn from the focus groups. The final online documents were the outcome of the initial single rheumatologist-applied linguist research collaboration, now recontextualised and given institutional sanction. The most salient elements were adopted and, pleasingly, some of the ethos of the ELF was translated in unforeseen ways. Not all of our recommendations were taken up, however. Using the journey of one of the leaflets as an example, this paper categorises these tacit decisions into those based on the discursively produced identities of the writer-voice and the presumed reader; on the semiotic resources deployed in the visual aspect; and on a certain resistance born of a commitment to the medical information.

Ulla Connor₁; Kathryn Lauten₁ (presenting author); Marta Antón; Stephanie Balunda; Elizabeth Goering; Amir Hayat; Paris Roach

Indiana University-Purdue University Indianapolis, USA

Intercultural Modeling of Health Literacy: A Study

This paper presents the final results of a 3-year study of an interdisciplinary and intercultural research project of patients who have diabetes. The purpose was to examine multiple dimensions of health literacy, based on patients' perspectives (van Dulmen et al., 2008), to create a new conceptualization and way of assessing health literacy in its broader sense that includes processing and acting on information in order to integrate those findings into interventions to improve health regimen adherence. Taking critical studies into account (Nutbeam, D., 2000; Von Wagner, C., Steptoe, A., Wolf, M., and Wardle, J., 2008), and through our study of the correlations between adherence and the ability to understand health information and turn it into knowledge and then into action, a model of the critical variables of adherence was developed.

The data consisted of video-taped interviews with 43 English-speakers and 21 Spanish-speakers in a Midwestern US

town. The interviews involved open-ended questions that elicited information about living with diabetes as well as questions on health beliefs, medication adherence, information sources and uses, literacy level and basic demographic information. The diabetes narratives were analyzed using grounded theory methodology. The quantitative data were analyzed using a multivariate analysis.

The presentation will focus on the results of the intercultural comparisons between what information sources were used in the English-speaking and Spanish-speaking subgroups and how those different sources were used.

The resulting intercultural model of health literacy and adherence will be discussed in terms of enhancing the patient-centered tailoring of health information and communication.

Jill Dales₁; Peter Phillimore₁; Alison Steven₂

Newcastle University₁, UK; Northumbria University₂, UK

'Communicating With Patients: The Influence of Prior Assumptions'

Background/objective: Doctor–patient communication has been the focus of many sociological studies.(Di Blasi et al 2001).e.g. the influence of clinicians' gender (Elderkin–Thompson & Waitzkin (1999);patients' socio–economic class (Hall et al 1998); adaptations in response to the patient's action (Street 2001).

Unique to the current study are the methodology and the inclusion of exploring the anticipated communication of the doctor prior to the patient being seen.

Data and method: The study is ethnographic using a staged approach to capture key aspects of the communication process: cognitive interviewing of the doctor during first sight of referral information to explore the 'anticipated communication'; observation of the consultation to identify the 'actual communication'; post-consultation interviews with the doctor to explore the 'anticipated' and 'actual' communication.

Findings: Provisional findings suggest a range of emerging themes e.g the doctor placing responsibility of the content of the actual communication either on the referrer; or the patient or them self. For some doctors, basic personal information regarding the patient e.g. name, age, gender is perceived as influencing their communication, whilst for others, the patient has no personal identity prior to being seen. In many instances, the actual communication has been very different from that anticipated.

Implications: Doctor–patient communication is essential to patient care. This study explores what impacts on that communication and may influence the way we teach communication skills to undergraduate and postgraduate doctors.

Maria das Graças Dias Pereira₁; Cina Monteiro Cortez

Pontifícia Universidade Católica do Rio de Janeiro₁, Brazil

Narratives of Community Workers in Tuberculosis Treatment

This study is linked to research projects with Vila Rosário Institute, for the prevention and education to combat tuberculosis in Duque de Caxias, Rio de Janeiro, Brazil. The objectives are (i) to show the co-construction of narratives about professional practice told by the institute community workers; (ii) to discuss values and responsibilities in the tension between institutional/professional and personal discourse. The research is inserted in Narrative Analysis studies (Labov & Waletzki, ([1967] 1997; Thornborrow & Coates, 2005; De Finna & Georgalopoulou, 2008), in a perspective of Applied Linguistics (Sarangi, 2006). The data consists in audio recordings and participative observation of work meetings from October to December of 2009. The analysis procedures relate to narrative structure, linguistics marks and discourse strategies, indicating co-construction, positioning and articulate discourse. Data analysis indicates that

the narratives focus on problems of professional practice in the tension between TB treatment and poverty/hunger. They are sequential, show hypothetical or actual daily events and are developed with collaboration of audience as co-author. They present a problem-situation opening and a subjective and agentive solution ending. Values and responsibilities arise from the workers' actions, which point out agency through either religious or political view and go beyond professional attributions, replacing the government role. Recent changes have led to narrative studies as social interactional practice and experience interpretation in relation to moral order structures (Taylor, 1989; Howard, 2008). The narratives told by the community workers in Vila Rosário bring reflections on professional practice and provide meaning to their problems.

Boyd Davis,¹; Charlene Pope; Bertha North-Lee

University of North Carolina at Charlotte,¹, USA

Expanding Explanatory Models: The Embodiment of Agency and Accountability in the Talk of Diabetics

Diabetes is nearly three times more prevalent among Veterans than in the general population (20% vs 7 %). This presentation uses methodology from sociolinguistics to examine interviews from an ongoing study of Veterans with Type 2 diabetes in the Veterans Affairs (VA) health system. A variety of dimensions of communication have been studied in relation to diabetes care and self-management (messages, patient-provider interactions, narratives, explanatory models, barriers, preferences, attitudes, beliefs, health literacy, family communication, and multicultural variations). This study uses the communication technique called cognitive mapping for data collection to build stories that map a typical day living with diabetes. Building on Nancy Krieger's (2005) definition of embodiment, how people use language to discuss their diabetes embodies the conditions and contexts in which they

live and reveals assumptions, expectations, and contradictions that lay below the level of the story they tell. Fifty Veteran accounts from cognitive mapping are prepared as a corpus or collection of transcriptions. These accounts are then analyzed in two ways. Using the corpus analysis and comparison tool, Wmatrix, frequency lists and concordances common in linguistics provide a means to examine how language is used in function and context, how patterns of phrases portray intention, agency, and accountability, and how language use suggests social positioning. Then, patterns in talk are interpreted using discourse analysis and suggest how people rationalize and make decisions. Specific semantic patterns show how diabetics embody their interpretation of the disease and reveal their own contradictions, oppositional forces, and feelings about agentive behavior.

Clare Delany₁; Jane Galvin₂ (presenting author); Melati Conwell

Murdoch Childrens Research Institute and Department of Physiotherapy, School of Health Sciences, University of Melbourne, Australia;₁; Children's Bioethics Centre, Royal Children's Hospital, Australia₂

Ethics and Communication in Pain Management for Paediatric Procedures; Lessons from Play Therapy

Background: Increasing survival rates for children with cancer and other acute and chronic conditions mean more exposure to assessment and treatment procedures. A key ethical ideal and presumption of the multidisciplinary approach is that professional resources and perspectives from allied health and medical disciplines will be both integrated and complementary towards acting in the best interests of each child. In the area of pain management and preparation for procedures such as MRI, needle biopsy and imaging techniques there is little research and knowledge about how different health professionals interpret a child's best interests.

Methods: Qualitative in-depth interviews mapping allied health clinical ethical issues in a large Children's Hospital, Melbourne, focusing on play therapist interviews.

Findings: Play therapists draw from educational theories including Vygotsky's scaffolding theory, to develop

age appropriate and realistic play opportunities and language and communication techniques. Their role includes educating and empowering children, families and other members of the health team to decrease both short and long term effects of pain, stress and emotional and physical trauma associated with single or ongoing procedures including general anesthetics, medical imaging and surgery.

Implications: The research highlights how the perspectives and communication-based techniques offered by one allied health group, play therapists, have the potential to advance a more integrated and evidence based approach to defining and maximising a child's and their families' best interests when undergoing procedures in acute and chronic care. More broadly, the findings provide a framework for advancing the integration of different disciplines to achieve ethical ideals in health care.

Guadalupe delCarmenAlvarez-Gordillo,; Katherine Careaga

El Colegio de la Frontera Sur¹, México

Social Constructions of the Body among Youth in Comitán, Chiapas, Mexico

In the context of globalization, the municipality of Comitán, Chiapas, Mexico has been undergoing significant economic and cultural restructuring. This study links such global processes to local conceptions and negotiations surrounding body ideals and related health behaviors. Twelve group interviews of 8 to 10 youth were conducted with urban high school (preparatoria) students and rural youth ages 15 to 18. Six of these groups consisted of young women, and six of young men, permitting gender comparisons. This is a generation that has rapidly and increasingly adopted modern technologies such as cellular phones, digital music players (iPods), personal computing, and media all of which facilitate their access and exposure to a wider worldview. The negotiation of such values can be observed through mechanisms such as social pressure among peers at the local

level.

Interviews revealed information on body image and ideals, the social spaces of teen interaction related to the body, dietary practices, and sports engagement. Discourses reflect the dialectics of consumerism- control and body acceptance-dissatisfaction. Among women, the body is represented as fragmented, both in terms of parts and in a disconnect between the body as an object (of desire, for others) and functionality. “Caring for the body” is seen as a female activity, while sports is increasingly male-dominated with age. Free time and social interaction primarily consist of sedentary activities such as watching television and movies, and also imply consumption of high caloric foods. Time constraints and marketing lead to the consumption of convenience foods with limited nutritional value.

Patrick Dillon

University of South Florida, USA

*Moral Accounting and Membership Categorization in Primary Care
Medical Interviews*

Background: Medical interviews are often associated with the exchange of facts related to the physical nature of medical problems, but talk of health can never truly avoid issues of morality. Scholars have long posited that health behaviors constitute an important role in constructing definitions of moral character, such that, to be healthy is to be a “good” person (Stephens & Breheny, 2008); however, few studies have examined health and morality through an analysis of everyday medical discourse. This study addresses this relationship by examining how issues of morality emerge and are addressed in talk between patients and physicians.

Method: This study utilizes the ethnomethodological approach of Membership Categorization Analysis (see Hester & Eglin, 1997) to examine recordings of 96 medical interviews.

Findings: This analysis reveals that patient-physician interactions are “saturated” with moral talk, as issues related to smoking, adolescent pregnancy, parenting, infidelity, and obesity are addressed. More specifically, it reveals that patients orient to particular membership categorizations and distance themselves from others in order to address the moral implications of their behaviors through defensive detailing, prioritizing membership categories, and promising future action.

Implications: If we are to understand the relationship between health and morality we must heed Bergmann’s (1998) call to examine morality as it is constructed in and through everyday interactions in health institutions. This study provides preliminary insights into moral discourse in medical encounters, but if we are to truly understand, and ultimately improve, patient care, there must be a concerted effort to examine morality in physician-patient interactions.

Rony Duncan¹; Ann Knowles; Annette Hall; Susan Sawyer

Murdoch Children's Research Institute¹, Australia

*Psychologists who Breach Confidentiality with Adolescent Clients:
Transparent Communication as a Means of Minimising Harm*

Confidentiality is a vital piece of the therapeutic puzzle in psychology. It allows clients to speak honestly and psychologists to build effective therapeutic alliances. However, it can be challenging to determine when a breach of confidentiality is necessary to prevent harm and how to facilitate such breaches appropriately. These challenges are further complicated when clients are minors, as young people differ from adults in their emotional, social and cognitive capacities. The current study aimed to explore the practices of Australian psychologists who work with young people in relation to breaching confidentiality with adolescents. An online survey of members of the Australian Psychological Society was conducted; 264 respondents provided details about when they believe it is ethical to breach confidentiality and the factors that mediate their decisions. Semi-structured telephone interviews

were then conducted with a sub-cohort of respondents to elicit more detail. Responses to the survey were analysed using factor analysis. Interviews were recorded, transcribed and analysed for recurring themes using a grounded theory approach. While Australian psychologists demonstrated consensus about the need to breach confidentiality when a serious and immediate risk of harm was present, great variation existed in their opinions about less imminent risks. They described significant difficulties associated with making decisions about confidentiality, expressing a desire for greater support. Transparent communication with young people and their families, initiated early in therapy, was a key strategy used to minimize potential for harm. These findings have implications for the training of current and future health professionals who work with adolescents.

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Murdoch Childrens Research Institute₁, Australia

Parents' Understanding of Confidentiality when their Teenage Children See Clinicians Alone: a Matter of Miscommunication?

Fears about confidentiality form a major barrier to adolescents seeking health-care. For this reason, combined with a philosophy of providing developmentally appropriate care, guidelines in adolescent medicine recommend seeing young people alone for part of each consultation, without parents. This ensures young people's developing autonomy is respected, allowing discussions about sensitive topics without parental knowledge. It also allows young people to practice seeing clinicians on their own; a skill they will require as adults. While research is available to confirm young people's support for confidentiality, remarkably little is known about parental opinions.

The current study aimed to explore the views of parents of adolescents about appropriate limits to confidentiality. A total of 83 parents who brought their children to an adolescent medicine clinic at a major hospital in Melbourne

completed a short questionnaire comprising 30 questions about their understanding of confidentiality and their beliefs about when information should be shared with them. Findings indicated that parents are generally in favour of confidential health-care for adolescents. However, their understanding of the limits to confidentiality differs significantly from what is contained within clinical guidelines. Parents believe that a far greater range of information should be shared with them than is currently legally or ethically required. This raises questions about to what extent miscommunication is occurring between clinicians and parents about confidentiality. The results of this study suggest a need to rectify this through better training of health-care professionals and new strategies for provision of information about confidentiality to families.

Anke Dunkel₁; Peter Schulz₂

**Institute of Communication and Health, Switzerland₁;
University of Lugano, Switzerland₂**

Targeting Health Messages in Switzerland

Recent studies in Switzerland showed that there are cultural differences among language groups in terms of knowledge and attitudes towards certain health topics.

To examine the cultural differences two surveys have been conducted in the three main language regions of Switzerland. During a first written survey interviewees were exposed either to an informative, emotional or community oriented flyer about organ donation. In the follow up telephone survey four weeks later, people were asked whether they remembered the flyer and if so how they appreciated it. Results show that compared to Swiss French and Swiss Italians, Swiss Germans significantly more often showed a biased recall ($X^2(8, N=312) = 39.659; p < .001$) which was either positive or negative depending on the version of the flyer. Our hypothesis saying that Swiss Germans are more likely to appreciate the informative and

not the emotional flyer was confirmed ($X^2(8, N=93) = 27.250; p < .01$). Interestingly, among Swiss French and Swiss Italians there were no significant differences which we could argue might be due to their "Latin character" but this is contrary to our hypothesis saying that the Swiss Italians would be most reactive to the community oriented flyer. Actually, among those who read the community oriented flyer the Swiss French were the language group who appreciated it most ($X^2(8, N=100) = 22.014; p < .001$). However, confirming our theory Swiss Germans very much disliked the emotional flyer criticizing it when asked for what they would recall from the flyer ($X^2(8, N=109) = 24.000; p < .01$). During the conference we will present the main findings of this study proving that targeting health campaigns to micro-diverse groups (in Switzerland) might be necessary.

Natalie Ellery

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'Jumping Hurdles': Experiences of Predictive Testing for Huntington's Disease in Young Adults

Undertaking predictive testing for Huntington's disease (HD) as a young adult is life-changing. Previous studies on HD predictive testing in young people have not focused on the experience of the testing process itself, where there might be tensions between clients' and counsellors' expectations. This study reports on the predictive testing experience from the clients' point of view. 4 in-depth, retrospective interviews were held with participants who requested predictive testing between the ages of 18-22.

Using theme-oriented discourse analysis (Roberts and Sarangi 2005) the following focal themes were identified for further analysis; genetic counsellors as the gatekeepers of the test; the ordeal of testing; communicative challenges faced by both the counsellors and the clients. Participants saw it as their right to know their genetic status 'here and

now', but reported the genetic counsellors to be withholding the test. Convincing the counsellors to provide the test was described as a test in itself, which was metaphorically captured as 'jumping hurdles'. In other words, the predictive testing process was seen as more of an ordeal than receiving a positive HD result. The tensions between those seeking the test at a young age and those offering the test were apparent. These findings contribute to the relatively unexplored field of research concerning HD predictive testing in young adults, although given the small sample size, no generalisations can be drawn. This research aims to open up discussion on how best to offer predictive testing to young adults to make this process easier for both clients and clinicians offering the test.

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Communicating Adverse Patient Events in Surgery: The CAPES Study

Background: There is an ethical imperative for surgeons to disclose unanticipated adverse events to patients, in a forthright, timely and empathic manner. Few studies have examined the communication of actual adverse events from both surgeons' and patients' perspectives.

Objective: To examine how surgeons communicate adverse events to their patients, and to explore the perceptions and meanings of this communication from both surgeons' and patients' perspectives.

Methods: Nine surgeon-patient pairs participated in separate, semi-structured interviews approximately one month after an adverse event. Both interviews focused on reports of the communication, feelings and perceptions about the communication and the event. Narrative analysis was used to examine and compare form and content of stories told about disclosure by surgeons and patients.

Findings: Surgeons expressed guilt in having not accomplished what they intended to, yet in communicating with patients, agency for the event was placed elsewhere, as in "I'm sorry this happened to you". The feared impact on surgeons' professional reputations was often more difficult than communicating with patients. Patients responded with gratitude, despite the inconvenience of more surgery, as long as their health ultimately improved. Patients reported that surgeons were apologetic and concerned about their welfare. Those who reported a close relationship with surgeons reported disappointment but not anger about the event.

Implications: Among these surgeons and patients, relationships matter when discussing sensitive medical outcomes. Providing feedback to surgeons on positive communication examples may enhance their willingness to establish relationships with patients and create open and empathic discussions about unanticipated adverse events.

Gemmae M. Fix₁; Jeffrey L. Solomon; Ellen S. Cohn; Dharma E. Cortés, Nora Mueller; Barbara G. Bokhour

**Center for Health Quality, Outcomes, and Economic Research₁,
USA**

“When I Found Out I Had All The Sickness”: Using an Illness-Web to Understand Patient Barriers to High Blood Pressure Management.

Background: Almost a third of Americans have high blood pressure (HBP), a major risk factor for stroke and heart attack. Despite the risks, two thirds of patients who are aware of their HBP are still uncontrolled. This study explored patient barriers to control.

Methods: In-depth, semi-structured interviews about HBP management were conducted at two US Veteran Affairs Medical Centers with 48 patients with uncontrolled HBP. A multidisciplinary team analyzed the interviews using emergent thematic analysis.

Findings: When asked about HBP control, participants responded with stories about other social and health factors. Emergent findings suggest that patients have difficulty disentangling symptoms and treatments for multiple ailments. They expressed concern about the harm in taking numerous medications and worried about potential interactions. Because HBP has no

symptoms, patients may attend more closely to other conditions in which treatment has a perceptible effect. Participants discussed difficulties with complex or seemingly conflicting management regimens. They struggled with incompatible health recommendations, such as exercise, which can be difficult for people with limitations in lung function or mobility.

Implications: Findings suggest a new model of barriers to HBP control in which patients manage illnesses within the construct of an illness-web, in which HBP is not compartmentalized, but overall health is managed within their life context. Conceptualizing HBP within a bio-cultural model of health affords the ability to better understand the intersections of multiple health conditions. To better meet patient needs, providers should integrate HBP management strategies within the context of patients’ other health and social priorities.

Eleanor Flynn,; Robyn Woodward-Kron; Geoff McColl; Diana Slade; Gillian Webb; Jonathan Knott

University of Melbourne, Australia

The State of Emergency Communication Skills Teaching in Australian Undergraduate Medical Education: Gaps, Barriers and Opportunities

Communication problems in Emergency settings are a major cause of complaint and poor patient outcomes. While communication skills teaching is now a core component of medical undergraduate curricula, this often occurs in non-clinical settings. Separating the teaching of communication skills from the clinical setting emphasises the effect of the hidden curriculum and neglecting students' communication skills training in emergency settings could have implications for patient safety and health.

We report on the initial scoping phase of a national project to develop methodologies and resources for teaching communication skills for medical and nursing students. We collected information on teaching and assessment of communication skills for medical students both in general and Emergency situations, undertook a literature review of communication skills teaching in relation to emergency

settings and elicited student and tutor perspectives on communication skills as experienced in emergency settings. Communication skills training is a core requirement in all Australian medical schools. No school conducts specific communication skills in Emergency settings although 68% incorporate communication skills into advanced life support simulation teaching sessions. There are few papers describing programs teaching Emergency communication skills to undergraduate medical students, though many report the importance of communication in Emergency settings and the particular communication demands in Emergency. Student focus group interviews after their emergency department placements showed the medical students were more engaged with the 'hands on' clinical aspects of the rotation and considered that "communication can come by osmosis". The discussion considers how this information can be used to develop acceptable teaching resources.

Yvonne Ford

Western Michigan University Bronson School of Nursing, USA

The Things Nurses Talk About: Nouns in a Corpus of End-of-Shift Hand-offs

Hand-offs represent a transition of responsibility for patients' care. While the meaning of hand-offs to nurses has been previously described, there is little description of the language used by nurses during hand-offs. The objective of this analysis of a corpus of nurses' hand-offs was to identify the patterns and frequencies of nouns used by nurses during end-of-shift hand-offs.

Methods: Forty-three end-of-shift hand-offs from 8 nursing units in 4 hospitals were recorded and transcribed. Word frequencies were identified through corpus analysis. Keywords were identified by comparing the hand-off corpus to the British National Corpus of spoken English and the Michigan Corpus of Academic Spoken English (MICASE).

Findings: Word frequency analysis revealed that nouns describing body parts and functions, time, and location

were most frequent in the corpus. Results of the keyword analyses indicate that nouns describing time demonstrate that nurses' hand-offs focus on narrower windows of time than do speakers of general spoken English.

Implications: Although nursing presents itself as a profession that considers the physical, psychosocial and spiritual dimensions of patients, hand-off language indicates that their focus is on the physiologic domain. The finding that nurses' discussions of time focus on narrower windows of time than general English conversations may be an indication that bedside nurses focus on caring for the patient within a narrow period of time while they are hospitalized, and do not expand their view of patients beyond the hospital. This finding has implications for continuity of care, discharge planning and post-discharge follow-up.

Yvonne Ford

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Moves and Strategies in the Genre of Nurses' End-of-Shift Hand-offs

In healthcare settings, the transition of responsibility for patients' care is a hand-off. Hand-offs by nurses occur daily in hospitals, and have recently been identified as potential sources of miscommunication and/or patient care errors. As communicative events, the purpose of which is transmitting information about patients' care and status, hand-offs are a language genre, yet have not been described as such. The objective of this descriptive analysis was to identify the move structure of nurses' hand-offs.

Methods: Forty-three end-of-shift hand-offs from 8 nursing units in 4 different hospitals were recorded and transcribed. A four-move structure was identified by close reading and re-reading of the hand-offs. Each move contained several

Findings: Hand-off moves included: 1. Introducing the Patient; 2. Relating the Events of the Shift; 3. Looking Ahead; and 4. Wrapping Up. There was variation in the sequence and frequency of the moves; although every move included Moves 1 and 2, Moves 3 and 4 were found in just over half of the hand-offs. The use of strategies also varied, with those focused on tasks and test results appearing most frequently. There was no move that addressed goals or recommendations for the patient's care.

Implications: The results of this study demonstrate that nurses communicate during end-of-shift reports in a repeated or cyclical manner, rather than in the "linear" structures most commonly recommended for standardization of hand-offs (e.g. S-BAR, 5 P's). The lack of a move addressing goals for care may represent a risk for omissions in patient care and management.

Kempa French

Austin Peay State University, USA

Measuring the Suitability of Printed Patient Educational Materials

Health care providers rely on printed patient educational materials (PEMs) to communicate essential health information to patients. Printed PEMs are frequently written at unsuitably high grade levels or are contextually inappropriate for the intended audience. Five instruments have been used to assess the suitability of PEMs: AHEC, SAM, SAM + CAM, TEMPtED, and UFT. The creation of an additional instrument to measure the appropriateness of food security concepts in PEMs has also been documented (Tolma et. al., 2007). A literature review found that suitability concepts differed between the instruments but all included core dimensions of readability levels, graphic and layout elements, and content appropriateness.

Method : A total of 204 articles were collected by electronically searching

MEDLINE (Ovid), Cochrane Library, Academic Search Premier, ERIC, Health and Wellness, CINAHL, and Google Scholar from 1996 to 2009 using combinations of the keywords "health literacy", readability, suitability, and instrument.

Findings: Thirteen studies were identified: 1 using AHEC, 1 describing the nutrition specific tool, 2 using UFT, 7 using SAM, 1 using SAM + CAM, and 1 using TEMPtED. The majority of studies document inter-rater reliability but are limited in their support for other measures of reliability or validity.

Implications: SAM has been the instrument most widely supported and used in PEM suitability evaluations but further psychometric research should be conducted using the SAM + CAM or the TEMPtED instrument.

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Defining and Measuring Health Literacy: How Can We Profit from Other Literacy Concepts?

Introduction: Health literacy includes a set of skills individuals should possess to enable health-conscious behavior. As such it builds on general literacy concepts and it is only one of many context specific literacies that have emerged during the last decades. While theoretical works on health literacy attempt to develop conclusive universal definitions by including a variety of skills (see, e.g., Schulz & Nakamoto, 2005; Rubinelli, Schulz & Nakamoto, 2009), empirical studies concentrate on restrictive workable definitions dependent on the research question and population under investigation (Paasche-Orlow et al., 2005).

Objectives: To overcome this discrepancy between theory and practice we aim to create a topology of literacy concepts to show systematically which skills have been identified in the literature and how they have been operationalized in contexts other than health. We expect that such a topology helps to better understand to which extent health literacy can and shall be measured to meet theoretical

definitions.

Methods: We derived several criteria to map existing literacy concepts. These are, e.g., lite-racy dimensions (ranging from basic reading, writing, and numeracy skills to more advanced skills such as critical thinking skills and others), literacy settings (related to the individual, family, community, and society), and literacy contexts (e.g. the media, environment, culture, science, health).

Findings: The resulting topology of literacy concepts shows that the majority of conceptual works define context specific literacies as multidimensional concepts that concern more than just the individual. It confirms the necessity to define and measure health literacy beyond basic reading and writing skills. In how far we can make use of advanced measurements developed in other literacy contexts will be eventually discussed.

Felicia Marie Gabrielsson; Roar Stokken (presenter)

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Unempowering Love: On Patient Choice and Professionalism

Objective: In this article, we highlight communicative challenges relating to negotiation of care. In Sweden, health care experiences an increasing focus upon patient's right to choose. On basis of discharge planning, we discuss the consequences of this from a care-perspective.

Theory: While Parsons frame the health worker as the patient's guardian, modern health service conceives health professionals as partners to autonomous patients that got the right to choose. Mol frames the contradiction between these two to be between the logic of care versus the logic of choice.

Material: Our discussion is based upon investigation of 27 discharge planning processes. In addition health professionals were interviewed and observed at discharge-planning

meetings. In the empirical section, we investigate one case thoroughly. The case concern Ida that is eager to go back home, and her spouse that due to experiences not dear to take her home.

Findings: The result is Ida moving into an elderly nursing home. At the end of the meeting, when the discharge planning team has left, Ida's spouse apologies for – of love to her – not daring to have her at home. We discuss the contradiction between respecting choice and taking on the role as carer for other person's wellbeing. In special we investigate the discharge planning team respecting the choice of Ida's spouse, without investigating the case further. The result is that all parties act from meagre information, and a situation where all parties in some sense becomes losers.

Jane Galvin,¹ Clare Delaney

The Royal Childrens Hospital,¹ Australia

Sharing Big Decisions with Children and Families: An Occupational Therapy Example

Background: Four features of effective clinical shared decision-making are that 1) it involves at least two participants – a health practitioner and a patient, 2) information is shared 3) there is participation in the process of treatment decision-making and 4) a treatment decision is made and agreed upon.

Methods: We draw from qualitative research mapping ethical issues in paediatric allied health practice to present a clinical case study about shared decision making in paediatric occupational therapy practice. The case highlights both practical and philosophical challenges that impact on the achievement of shared-decisions. Six year old ‘Sophie’ presents with a dense hemiplegia of her dominant left side. Her parents say she is a good student, with good handwriting abilities. They are hopeful for a quick and full recovery. The occupational therapist must decide whether to focus on developing fine

motor abilities in the previously non-dominant hand, or on rehabilitation and recovery of motor skills of the affected hand.

Findings and implications: Occupational therapists implicitly or explicitly adopt a philosophical position on whether to re-educate for short-term functional outcomes or whether to aim education and interventions for longer term recovery. This needs to be shared with Sophie and her parents in a way that acknowledges and incorporates their current and future needs and circumstances.

In allied health paediatric practice, clinical decisions are rarely limited to two people exchanging information. We draw from the science of complex adaptive systems to suggest practical strategies to facilitate the achievement of effective information sharing in complex paediatric health settings.

Lewis Glinert₁; Jon Schommer

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Manufacturers' Prescription Drug Web Sites: A Grey Area of Discourse and Ethics

Background: Manufacturers' prescription drug web sites are a grey area of discourse, regulation and ethics. Googling a medication, hit #1 is invariably the manufacturer's product site. FDA has eschewed guidance on Internet promotion, insisting that print ad regulations are adequate, despite Industry's pleas.

Method: We conducted a socially and institutionally situated semiotic analysis (Halliday 1978) of sites for the 100 best-selling drugs.

Findings: Sites had no obvious beginning, next page or conclusion; users move in mazes of texts and navigation choices, some leading far away; Web pages are harder to skim and flip. Pharmaceutical and other product sites lack a popular genre-name (like infomercial), and they are probably not a distinctive 'communicative project'. Despite their prevalence and Industry's nervousness, the drug sites themselves showed little routinization of design, coherence or logical order that could offer users a schema, except for home

page promotional visuals and 'under-the-fold' warning text, owing presumably to the forces of commercial culture. Information and promotion mixed unpredictably, content, verbal style, visuals, and paralinguistic features (font, layout etc) serving sometimes to distinguish and more often to fuse the two. If this is professional-lay communication, authority was backgrounded and often vague, with little reference to experts; however, unlike Web 2.0 practice, participants were not actively involved. Another ethical challenge to usability --and regulatory fair balance -- was 'Safety information', commonly set small in large unbulleted blocs below each page's scrolling 'fold', detached from while subordinated to promotional text and visuals.

Implications: FDA policy ignores how differently the Web works. Findings may suggest further empirical research as well as analytical perspectives of evaluation, leading to ethical and usability improvements.

José Carlos Gonçalves; Alexandre Jacome

Universidade Federal Fluminense (UFF), Brazil

Interaction and Discourse in a Context of Change in Brazilian Medical Education: a study on Problem Based Learning

Background/objective: Medical education in Brazil has undergone changes in its guidelines with a view towards constructing a reflexive and critical professional. For this purpose active teaching and learning methodologies, such as Problem Based Learning (PBL), have been implanted in Brazilian medical schools in the last ten years, under the sponsorship of governmental programs. In this context, this study aims at analyzing in which ways the construction of knowledge in the first semester of a Medicine course undergoing curricular change takes place, so as to understand the practice of this methodology in tutorial sessions.

Data and method: For this purpose, data of tutorial sessions are analyzed through the ethnographic microanalysis of talk-in-interaction in institutional context as a fundamental analytic tool (cf. Duranti, 1988; Erickson, 1996; Sarangi, 2001; Heritage, 2004).

Findings: The data indicate that knowledge, in the session analyzed, is being constructed in interaction with significant students' participation; nonetheless, there is an emphasis on the internalized knowledge of students and tutor, in detriment of the scientific knowledge. Due to the students' new alignment as producers of knowledge, power relations seem more uniformly distributed. Although the relationship with patients constitutes a sub-topic of the interactional agenda doctors' technical role in the problem-situation is emphasized.

Implications: As a follow-up, the analysis scope will be broadened to include other data, in order to map zurthose interactional patterns. Reflections on the role of the tutor in this teaching methodology are also provided.

Lisa Gualtieri,¹; Pamela Ressler

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Bloggng for Health: Communicating the Experience of Illness

Background/objective: This paper explores the motivations and perceived benefits of individuals who regularly blog about a chronic illness. Currently 5% of U.S. adults write a health blog [1]. With more than 133 million individuals living with chronic illness in the US [2], free blogging platforms readily available, and increased visibility of health blogs on hospital [3] and media Web sites [4,5], the number of people writing health blogs is likely to grow.

Data and method: We conducted a qualitative preliminary survey study of individuals diagnosed with chronic illness. The 22 respondents, 18 of whom wrote health blogs, were self-selected to participate by responding to an email request or tweets.

Findings: The reasons for starting and maintaining a health blog include communicating with family and friends, tracking the progression of the disease, recording details for future reference, as a means of helping others, and as a means of expressing feelings.

Respondents differed in how long they kept a blog for, whether they identified themselves by name in the blog, how frequently they wrote, the amount and type of feedback they received, and whether they showed the blog to their healthcare providers. Of respondents who did not blog their illness, the reasons included that they that they never thought to, were too depressed, didn't want to think about their illness when they didn't have to, or were concerned about privacy.

Implications: The goal of the next phase of this study is to understand the benefits of health blogs from the perspectives of patients, their family and friends, others with the same disease, and healthcare providers. The responses to this initial study indicates that there is a need for a more comprehensive research to better understand blogging as a tool for communicating the experience of illness.

David Hewett₁; Bernadette Watson; Cindy Gallois; Michael Ward; Barbara Leggett

School of Medicine, University of Queensland, Brisbane, Australia,₁

A Survey of Communication between Hospital Doctors: Accommodation and Comprehension

Background/objective: Hospitals are complex adaptive systems comprising multiple connected or interdependent subsystems. Individual care-givers are thus required to cooperate and collaborate for patient care. Research indicates the importance of social and group identity to communication within organizations. The purpose of this study was to evaluate the nature and impact of an intergroup climate on communication between hospital doctors, and on patient care.

Data and method: One hundred forty-seven doctors from several specialties, based in the same hospital, completed a self-administered questionnaire on perceptions of responsibility for patient care, perceptions of their own and other specialties, and beliefs about hospital policies. In addition, they interpreted medical record entries by members of their own or other specialties.

Findings: Results indicated disagreement across specialties over which doctor should take responsibility for multiple aspects of patient care, with differences predicted by group memberships. Doctors also believed that patient care was best handled across specialists at the same level of seniority. In written communication, doctors used language based on group membership, whether the audience was in- or outgroup. Thus, participants interpreted medical records written by outgroup doctors worse than ingroup doctors did.

Implications: This study confirmed the intergroup nature of hospital communication, and its impact on patient care. The lack of intergroup understanding of written communication threatens the quality of patient care and increases the risk of inadvertent patient harm.

Jan Hodgson¹; Lynn Gillam; Margaret Sahhar; Sylvia Metcalfe

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An Australian Study of the Process of Prenatal Genetic Counselling

Background and objectives: Many pregnant women in Victoria, Australia have a Maternal Serum Screening (MSS) test either in the first or second trimester of pregnancy. These screening tests can indicate an individual's risk of having a baby with a chromosomal anomaly.

Women who receive an 'increased risk' result are generally offered genetic counseling in order to provide information about their test result and the options available for diagnostic testing such as amniocentesis. Due to a lack of process studies there is currently little known about how women experience this phenomena or how well genetic counseling achieves its aim of facilitating informed decision-making.

Methods: Pregnant women attending genetic counseling following an increased risk result from a screening test were approached to participate. 21 'increased risk' genetic counseling

sessions and 15 follow up interviews were audio-taped and transcribed. Thematic, discourse and content analysis were utilized to explore both the process of prenatal genetic counseling and women's experiences.

Findings: Analysis of the counseling sessions revealed several tensions and mismatches in client/counselor communication particularly when talking about sensitive issues such as disability and abortion. Findings from the follow up interviews demonstrated important differences in women's decision-making processes and their perceptions of the role of genetic counseling.

Implications: These findings reveal the challenges inherent in discourse about prenatal diagnosis and highlight the potential for genetic counseling to facilitate informed decision-making in the prenatal setting.

Lars-Christer Hydén

Linköping University, Sweden

Non-Verbal Vocalization and Intersubjectivity in Alzheimers Disease

Alzheimer's dementia (AD) is often associated with a loss of social abilities. An example of this is screaming and other kinds of vocalizations by persons suffering from AD, often interrupting ongoing social interaction or are just generally disturbing at for instance care facilities. Non-verbal vocalizations (NVV) has often been defined and studied as more or less meaningless symptoms of AD. This would predict NVV as more or less random and socially being without sense and meaning. This study has been conducted in order to investigate whether NVV occurs without any respect of the specific interactional context and whether other participants treat NVV as meaningless. The study is based on

extensive video-recordings of the social interaction both between persons with AD and between persons with AD and staff. Analysis focus on the context in which NVV occur, especially in relation to the turn organization of the ongoing interaction. The analysis shows that other participants actively try to understand the NVV by presenting hypotheses about the meaning of the NVV, for instance as a pain expression, and then test these hypotheses. Through this interpretative activity the intersubjective organization of the interaction is upheld and negotiated. A general conclusion is that if utterances and responses in interaction are treated as if they are meaningful, they will be meaningful in their consequences.

Lars-Christer Hydén

Linköping University, Sweden

The Listener's Task in Dementia

In research on language use in Alzheimer's disease (AD) focus has largely been on the diseased person's linguistic abilities. Less interest has been paid to the tasks of listeners in conversations with persons with AD. This project aimed identifying strategies used by conversational partners in conversations involving persons with AD. A material consisting of video recorded naturally occurring conversations between persons with AD and other persons with mild or mid-stage AD, relatives and staff, was collected.

The analysis focused primarily on the turn-taking – inspired by the conversational analytic framework. It was found that in conversations between two persons diagnosed with mid-stage AD the listener never signaled conversational problems. In conversations involving two persons

diagnosed with early-stage AD both participants often addressed the conversational problems (for instance word finding problems) explicitly and found a way to deal with the problem. In conversations involving a person with AD and a participant with no AD, the healthy person generally allowed for very slow turn-takings giving the person with AD more time to find words. Listeners also scaffolded the conversation by suggesting an interpretation of the problematic turn, by suggesting a different way to produce an utterance (re-framing or re-formulating), and also by being very active in distributing turns and their formulations in the conversations.

This kind of knowledge is important in enhances the possibilities to live an active life with a communicative disability.

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Using a Video-interpreting Network to Improve Healthcare Communication for Limited English Proficient Patients

Background: Effective healthcare communication is critical to diagnosis and treatment. Many limited English Proficient (LEP) in the US cannot benefit from this fundamental interaction because their healthcare providers do not engage interpreter services due to the perceived financial burden. Yet, there is little empirical data regarding the costs and benefits of interpreter services. Our *objective* was to measure the costs and impact on quality of care of a large video-interpreting network

Methods: We used data from 8 network hospitals to calculate the average cost of interpretation per encounter within the network. Using a natural experimental design, we also examined whether or not length of stay (LOS) and test ordering in the emergency department (ED) and rates of admission to the hospital changed for Spanish-speaking patients

seen in the EDs of 2 network hospitals after the implementation of the video-interpreting network.

Findings: In > 52,000 encounters the average encounter time was 10.5 minutes and the cost was \$24.96. In the over 10,000 ED visits analyzed, there were no significant changes in ED LOS, test ordering, or rates of admission to the hospital for Spanish-speaking patients after the implementation of the video-interpreting network, although there was an average decrease in length of stay of 30 minutes at both hospitals.

Implications: Despite the documented lack of impact in this narrow realm, interpreter services, and their efficient provision through video-interpreting, have inherent value and moral weight. Timely, accurate communication is a universal need in health care that LEP patients should have equal access to.

Kirsten Jaeger; Annie Aarup Jensen

Aalborg University, Denmark

Culture-specific Assumptions and Expectations in Health Communication

Comparative health studies conducted in Western countries reveal significant health disparities between ethnic majority and minority groups. Furthermore, Danish studies on healthcare efficiency reveal services provided to minority patients to be more expensive and less efficient than those provided to majority patients. In Denmark and internationally, health disparities among ethnic groups are primarily related to diseases that are influenced by lifestyle factors (type 2 diabetes, cardiovascular diseases etc.) and therefore susceptible to advice given by healthcare professionals. Thus, statistics showing systematic health differences between ethnic groups indicate a weaker uptake of and compliance to messages communicated by health authorities in minority groups. It remains unclear, though, to which extent the apparently weaker impact of health communication among ethnic minorities can be explained by social factors hindering active health-

promoting behaviour, hazardous cultural practices, or factors within the healthcare system itself.

Based on a study combining a discourse analysis of all articles pertaining to ethnic minorities in the Danish nursing journal 'The Nurse' (2000-2008) and on data from interviews with a group of Danish nurses, this paper addresses the last-mentioned explanation by exploring to which extent Danish nurses' communication regarding ethnic minority patients involves culture-specific values, norms, and expectations and to which extent such views are communicated to minority patients. Findings indicate that culture-specific assumptions embedded in nurses' understanding of ethnic minority patients' health problems and in their attempts at introducing changes in these patients' lifestyles may contribute to insufficient uptake of health-promoting messages and non-compliance problems found in ethnic minority populations.

**Ilona Juraskova¹; Phyllis Butow; Ben Smith; Margaret Seccombe; Alan Coates Fran Boyle McCarthy Nicole Reaby
Linda Forbes John F**

The University of Sydney¹, Australia

Improving Informed Consent to Clinical Trials: A Randomised Controlled Trial of a Decision Aid for Women Considering Participation in a Breast Cancer Prevention Trial (IBIS-II)

Background/objective: Recruitment to clinical trials is generally suboptimal, with both patients and clinicians reporting difficulties with the consent process. Decision Aids (DAs), which present evidence-based information in a clear graphical form and facilitate participation in decision making, may improve this process by ensuring patients' decisions are informed and value-sensitive. This RCT evaluated the efficacy of a DA for women considering participation in the IBIS-II Prevention trial for women at high risk of breast cancer.

Data and method: Women eligible for IBIS-II, who had not decided about participation, were invited to take part in the DA study. Participants from 12 Australian and New Zealand IBIS-II centres were randomised to receive either the standard IBIS-II information and consent sheet alone (Control group, n=89), or in combination with a DA booklet (DA group, n=89). Participants

completed standardised and purpose-designed measures 1 week and 3 months after deciding about participation in IBIS-II.

Findings: Most women (84%) reported the DA made it easier to understand IBIS-II than the information/consent sheet alone, and 89% recommended providing both to potential IBIS-II participants. No group differences were detected in levels of decisional conflict or knowledge of IBIS-II/clinical trials in general, due to floor and ceiling effects respectively. No group differences were found in levels of decisional regret and satisfaction at follow-up.

Implications: This is the first study to assess DA effectiveness in a clinical trial setting. The use of a DA was strongly endorsed by participating women and clinicians. Challenges of evaluating DAs in a Prevention trial setting will be discussed.

Ilona Juraskova¹; Carissa Bonner; Gabbi Heruc; Caroline Andersen; Kath Nattress; Jonathan Carter

The University of Sydney¹, Australia

Improving Decision-Making in Ovarian Cancer: Development and Evaluation of Decision Aids to Help Women Make Informed Treatment Choices

Purpose: Women with ovarian cancer (OC) face difficult treatment decisions with uncertain QoL and survival outcomes. Decision Aids (DAs) have been shown to improve informed decision-making, but no such tools are available to women with OC. Study 1 involves an RCT to evaluate the effectiveness of a DA for asymptomatic women with rising CA-125 following initial treatment; Study 2 involves a pilot study to develop and assess a DA for women with resistant or refractory OC.

Method: In Study 1, 178 women are randomised to receive either the DA or a general Cancer Council booklet, and complete standardised measures at baseline and 4-month follow-up. This DA helps women decide whether to start immediate treatment or wait for further

evidence of cancer recurrence. In Study 2, 20 women provide feedback on the newly developed DA via a questionnaire and telephone interview. This DA helps women decide whether or not to continue active treatment.

Results: Overview and current progress on both studies will be presented.

Conclusion: This research program addresses a neglected area in the management of women with OC. It is anticipated that the DAs will lead to improved understanding of treatment options, reduced decisional conflict and regret, and increased satisfaction with the decision-making process. If effective, this relatively simple intervention has the potential to improve the clinical care, and ultimately quality of life, of women with OC.

Lauris Kaldjian₁; Laura Shinkunas; Marcy Rosenbaum; Jerold Woodhead; Lisa Antes; Jane Rowat; Valerie Forman-Hoffman

University of Iowa College of Medicine₁, USA

Ethical Issues Related to Communication Encountered by Third-Year Medical Students During Clinical Clerkships

Background/objective: Medical education in ethics and professionalism tends to be concentrated in the pre-clinical years through teaching in lecture or small group settings. To guide the content of this education, it is important to monitor ethical and professional issues students encounter once they move into the clinical environment.

Data and method: We performed a content analysis of Case Observation and Assessments (COAs) written by third-year medical students during their internal medicine and pediatrics clerkships (2007-08) at the University of Iowa. In writing COAs students were asked to describe and assess a clinical experience they observed during their clerkship that involved a patient and raised an ethical or professional issue of some kind. Coding was based initially on a published taxonomy and then modified. Four investigators coded COAs using an iterative process of consensus and NVIVO qualitative software.

Findings: A cohort of 141 third-year medical students wrote 272 COAs (average word count 771). Ethical and professional issues fell into 7 major domains: decisions regarding treatment (42.6%), communication (29.0%), professional duties (25.0%), justice (13.2%), student-specific issues (8.1%), quality of care (5.1%), and miscellaneous (13.2%). Communication issues contained the following 6 subcodes: inadequate communication, breaking patient confidentiality, delivering bad news, deliberate lies and deception in context of medical care, adolescent confidentiality, and disclosing medical errors.

Implications: Third-year medical students encounter a variety of ethical and professional issues during their internal medicine and pediatrics clerkships, a substantial proportion of which involve communication. These issues should guide pre-clinical curricular development and be discussed during clinical training.

Timothy Krahn

Novel Tech Ethics, Dalhousie University, Canada

Building Mental Health Ethics Literacy through Film

The practice of holding up our social attitudes and cultural mores to critical scrutiny and mining them for standards to give us guidance for determining how we ought to treat one another is part of the business of doing ethics. Building mental health ethics literacy can be understood as fostering recognition and discernment, critical reflection and assessment, of the mores that inform our understandings of mental health conditions and how these translate into treatment practices. Most basically, this process can begin by listening to the voices of ‘consumers’ and having those voices count towards the treatment they receive. In this regard, to make real listening possible involves unpacking those aspects of our culture that both facilitate and block us from hearing with understanding. Given the public interest in and public impact of film, what better

way to build mental health ethics literacy than to start a film series with panel discussions on mental health ethics issues?

The following presentation details the practical steps of how to build a mental health ethics film series as based on the author’s experience with STATES OF MIND 2007-2010. The first section outlines important questions to consider in establishing the purpose and choosing the programming of such a series. The second section explains how to assemble an effective panel and the pragmatics of reaching the diversity of stakeholders involved in mental health. The final section explains how to moderate the post-film discussions to create a space for interactive communication that builds mental health ethics literacy.

Jessica Kramer¹; Rosa Walker

Boston University¹, USA

“Give Them a Voice”: Therapists’ Perspectives on how the Child Occupational Self Assessment Impacts their Communication with School-Aged Children with Disabilities.

Objective: Communication between rehabilitation therapists and children brings a unique set of challenges, including unequal power dynamics, children’s use of nonverbal language, and adult assumptions regarding children’s ability to self reflect. Self-reports may offer therapists a means to solicit children’s perspectives. The purpose of this study is to better understand therapists’ perspectives about how one self-report, the Child Occupational Self Assessment(COSA), impacts their communication with children with disabilities.

Methods: Five focus groups were conducted (3 USA, 2 UK) with 33 rehabilitation professionals who used the COSA for at least three months. A semi-structured interview guide included questions about the COSA as well as questions related to barriers to the use of self-reports. Data were analyzed using a constant comparative approach; two researchers conducted line-by-line coding to identify descriptive and interpretative codes.

New chunks of information were compared with existing codes in an iterative process to identify themes.

Results: Therapists use the COSA to demonstrate their value for children’s opinions, facilitate children’s self-reflection, and identify interventions that are meaningful to children. Therapists “clarify” and “modify” the COSA using specific techniques that enable children with a range of abilities to effectively communicate. Using the COSA facilitates professional reflection, and enables therapists to “give children a voice” in the therapeutic context by raising professionals’ and parents’ awareness of the child’s perspective.

Implications: Self reports facilitate communication with children and increase professional awareness of children’s perspectives. Providing therapists with additional strategies to use in conjunction with self reports can ensure successful communication with children.

Lai Kun Tse

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Hong Kong**

*Transforming Experience and Learner Transformation: An Analysis of
First Year Medical Students' PBL Reflections*

Background and objective: Problem-based learning (PBL) departs radically from traditional pedagogy with the switch to learner engagement in active, self-directed, enquiry-driven, participatory and collaborative learning in small group discussions. In medical education, PBL aims to develop students into critical thinkers, effective communicators, and motivated, competent lifelong learners. Thus, PBL serves as a vehicle for transforming the educational experience, which will ultimately transform the learners. Despite this emphasis, research into PBL-inspired transformation has focused mostly on institutions, curriculum reforms and teacher development, with only scanty research into transformation at the learner level. This paper studies how medical students perceive PBL as a transforming experience and what changes they see in their understanding of PBL.

Method: The data consists of reflective texts written by 120 first year medical

students in Hong Kong. These texts were produced as the final outcome of a series of PBL-related reflective activities. The textual data were coded and categorised to identify central themes for analysis.

Findings: Analysis of distinctive features and patterns of the transforming experiences, and in terms of learners' perceptions of their transformation has yielded a picture of how the medical students see changes in their communicative behaviour in the new learning context and how their conceptualizations of PBL have changed.

Implications: The findings contribute to our understanding of the transforming capacity of PBL as actualised in individual learners. They also provide insights into how individual learners transform in different ways in a PBL context. These findings have implications for strategies for PBL induction and pedagogical facilitation for effective PBL.

Irit Kupferberg; Izhak Gilat

Levinsky College, Israel

The Construction of the Suicidal Self in Computer-Mediated Discourse

The paper explores the construction of the suicidal self in an open computer-mediated asynchronous forum for mental help. The theoretical framework comprises discursive psychology prioritizing the study of psychological and social phenomena in discourse, a functionalist approach to discourse emphasizing that language resources are self-displaying, and The World Approach advocating the focus on past experience, interpersonal communication, and possible future worlds in the quest for self-displaying language resources (Kupferberg, 2008).

Adopting this framework, a discourse analyst and a psychologist analyzed 65 suicidal and 65 non-suicidal messages qualitatively to identify and allocate language resources to the discourse worlds advocated by the approach. Messages were defined as suicidal when there was an explicit wish to commit suicide (Gilat & Shahar, 2009). To compare the two groups, the qualitative findings were quantified.

The analysis revealed that the density of irrealis (negation, future and conditionals) and figurative structures was significantly higher in the suicidal messages, whereas non-suicidal participants produced more realis structures (present and past tenses).

We interpret these findings as showing that to conceptualize cognitive and emotional complexity and pain, suicidal netizens (Crystal, 2001) resorted to irrealis structures and figurative language. The non-suicidal participants described the world of experience via realis structures to guarantee that help would be provided.

Theoretically, the study shows that language use is not arbitrary. Methodologically, it provides additional empirical evidence supporting the World Approach. The practical implications of the study can be used to further the help seeker-practitioner dialogue when language is the main resource in the assessment of illness and trouble.

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Neural Prosthetics – Public Understanding of Ethical, Social and Cultural Challenges

Advances in implantable neural prosthetics and the advancements of their possible uses, e.g., Deep Brain Stimulation for treatment of psychiatric disorders such as depression or obsessive-compulsive disorder (OCD), and sexual disorders have gained strong interest in recent years not only by the scientific and medical communities, but also by the public. Printed media have popularized these topics by and large to a point of more than idle curiosity. This novel technology has raised considerable ethical, legal, and social concerns in society. These same considerations are continually being discussed within the scientific community. Does the public share the same perception regarding these controversial issues? The aim of this

study is to investigate current discussions on neurostimulation technologies in German printed media coverage while focusing on public perception of ethical and social challenges. For this purpose twenty years of German print media (1990-2010) were analyzed. Both quantitative (descriptive statistics) and qualitative methods, such as metaphorical framing analysis and textual analysis were employed. The results show a communicative problem between the scientific community and the media. Varying strategies divide sides by charging the public's emotions through sensationalism rather than exploring their connectivity to ethical, legal and social issues.

John Launer

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A Narrative Based Approach to Teaching Supervision Skills

Issue: The London Department of Postgraduate Medical and Dental Education is responsible for 13,000 doctors and dentists in training grades across London. Since 2007 we have offered courses in supervision skills for the clinical educators who teach them. Our courses are the first systematic attempt in the UK to teach the interactional skills needed for good supervision. This workshop presents our experiences.

Methods: Our approach is based on ideas from narrative studies and social constructionism. It was conceptualised in the mid-1990s as a training for primary care clinicians, helping them to take a social constructionist approach to consultations. We then extended our trainings to cover supervision skills. We teach close attentiveness to language, and a responsiveness to the narrative brought by the patient or trainee. Much

of our teaching is done through small group work using observers and a coach.

Findings: Medical and dental educators are usually unfamiliar with these ideas but find them compelling. The ideas are effective in supervising peers and trainees. There are specific dilemmas about applying the ideas in highly technical specialities (where direct advice may be expected and is commonly offered) and also when there are concerns about a trainee's performance.

Implications. Many healthcare professions have dedicated trainings for supervision: medical and dental educators generally do not. We need more research on how our model impacts on educators, trainees and patients. There is also a need to develop and research further models of supervision training across postgraduate medical and dental education.

**Barton Laws; Ylisabeth Bradshaw; Steven Safren; Yoojin Lee;
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**Institute for Clinical Research and Health Policy Studies, Tufts
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*Physician Provision of Sexual Risk Behavior Counseling in HIV Care:
Direct Observation Using Mixed Methods*

Background: Consensus guidelines for HIV care call for routinely screening for sexual risk, and a brief risk reduction intervention in each visit. Studies based on self-report by physicians and patients find that this does not happen routinely. Studies based on direct observation of HIV care visits are lacking.

Methods: We analyzed 116 audio recordings of routine outpatient visits of 58 people with HIV. Using an innovative coding system that characterizes both the topic and interaction process for the entire visit, we identified all instances of discussion of sexual risk behavior; cues that might have prompted such discussion, such as a suspected STD or patient mentioning sexual activity; and compared interaction process in these discussions with other topics.

Findings: Discussion of patients' sexual risk behavior occurred in only 9/116 visits, in contrast to 53 and 115 visits,

respectively, with discussion of diet/weight management and medication adherence. In those 9 visits, the median number of utterances coded to the topic was 17 (range 2-99). Compared with discussion of medication adherence, physicians asked fewer questions and expressed fewer opinions, but provided more information. Patients asked more questions, made more expressive utterances, and made fewer reports about their behavior. Qualitative analysis found sexual risk behavior counseling ineffective. In 9 additional visits, a cue was present but no discussion of risk reduction occurred.

Implications: Guidelines for sexual risk reduction counseling are generally not followed, or are implemented ineffectively. Research into why physicians do not initiate such counseling, or provide it cursorily, is needed.

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Boston University₁, USA

Genetic Counseling Communication Patterns During the Disclosure of Genetic Susceptibility to Alzheimer's Disease and Their Effect on Patient Outcomes

Background/objective: Communicating genetics test results involves complex patient-provider interactions. While counseling regarding decisions to pursue testing has been examined, discussions of test results, essential to facilitating patients' comprehension and adaptation to personal genetic information, remain understudied. We identified patterns of patient-provider communication during the disclosure of genetic susceptibility for Alzheimer's disease (AD), and assessed the associations between these patterns and patient outcomes (psychosocial adaptation, information recall and satisfaction).

Data and method: Genetic counseling sessions involving 262 unaffected adult children of AD patients were audio-recorded and coded using the Roter Interactional Analysis System (RIAS). A hierarchical cluster analysis was performed to identify the interaction patterns. Regression modeling was used to evaluate associations between identified patterns and patient outcomes

immediately following the session and 6 weeks later.

Findings: The sample included 71% women, 21% African-Americans, and a mean age of 58. Three distinct patterns were identified: 1) counseling/patient-centered, 2) traditional biomedical focused, and 3) patient-driven medical focused. Measures of depression, distress, and anxiety (CES-D, IES, BAI), and test result recall did not differ between the patterns. However, patients in the counseling/patient-centered pattern expressed greater satisfaction with provider empathy, interest, and ability to meet patient expectations, as well as with the session overall.

Implications: While each test result disclosure session is unique, the interaction may conform to a small number of discrete patterns that result in different levels of some patient satisfaction domains. The results of this study further support the importance of providing patient-centered care when delivering complicated genetic risk test results.

Jen-Jyh Liu

Capella University, USA

Pervasive Telemonitoring For Patients Living With Chronic Heart Failure: A Quantitative Study Of Telemedicine

Background/objective: With pervasive computing, pervasive telemonitoring offers the potential of unrestricted and continuous healthcare that will benefit chronic disease management as well as acute care. This quantitative survey research addresses pervasive telemonitoring acceptance from a patient's point of view.

Data and method: The research used Technology Acceptance Model of Davis (1986) as the conceptual framework with two extensions: trust beliefs and self-efficacy. The research data was collected from a hospital affiliated telemonitoring program designed for a disadvantaged community with patients suffering from chronic heart failure conditions. A convenient sampling was used. The sample population was 181 with the response rate of 66.85% (N = 121). Logistic regression in SPSS

software was used for data analysis and hypotheses testing.

Findings: This research finds trust beliefs significantly positively influence a patient's intention to use the advanced telemonitoring. This study also finds perceived ease of use, perceived usefulness, and self-efficacy do not have significant direct predicting power in a patient's intention to use a pervasive telemonitoring within this research context, which is contrary to the results of most previous technology acceptance studies.

Implications: Trust building between healthcare providers and patients is imperative to telemedical application implementations. Telemedicine strategy is a complex issue. Organizations adopting telemedicine must strive to understand what factors influence patients' acceptance of the technology.

Laura Lorenz

Brandeis University, USA

Using Visual Metaphors to Communicate Lived Experience with an Invisible Injury

Brain injury can be a life-disrupting event that affects cognitive, emotional, and physical aspects of a survivor's life—consequences that pose challenges to understanding brain injury patients' perspectives on living with their injury. Furthermore the injury may be invisible, even clinically, causing additional confusion for affected individuals, family members, coworkers, and clinicians. My study used photovoice, a participatory research approach that uses photography and narrative, with eight adult brain injury survivors so they could communicate their experiences living with brain injury. Participants took photographs, discussed them

together, selected some for written captions, and prepared outreach products. Almost half of their 50 exhibit images are visual metaphors for their feelings about living with brain injury. One of the greatest challenges of living with an invisible injury such as brain injury is emotional—wrestling with the grief of losing former abilities and finding new meaning and purpose in life. This paper explores how visual metaphors contribute to meaning-making and coping with the realities portrayed, and play a pedagogic role in communicating lived experience and emotional reality.

Mbulungeni Madiba

University of Cape Town, South Africa

Language Acquisition Planning in South African Universities: Lessons from the Xhosa Communication Skills Courses for Staff and Students at the University Of Cape Town

In a country with eleven official languages, South African universities are faced with the challenge of producing health care graduates who have developed multilingual proficiency and intercultural communication competencies. Accordingly, the University of Cape Town in line with the National Language Policy for Higher Education (DoE, 2002) and its 1999 Language Policy (revised 2003), has introduced a number communication skills courses for students in the Faculty of the Health Sciences (MBCHB curriculum) and staff. The teaching of these courses raises questions of theoretical and methodological nature. The aim of this paper is to discuss the methodological paradigms adopted in teaching the courses and the extent to which these courses have been

successful in equipping staff and students with conversational and intercultural communication skills. Thus, the paper focuses on the Content and Language Integrated Teaching (CLIT) approach adopted for the course and then show how this approach has been implemented in the MBCHB curriculum and Xhosa Communication skills courses for Staff. A comparison of these courses is made to show how methods used in each of them provides a better alternative for teaching second or foreign languages in university's context. From an analysis of the evaluation reports based on the actual analysis of students' oral assessment transcripts, it is clear that the CLIT provides a better approach for language acquisition planning in South African universities.

Marie Manidis

University of Technology, Sydney, Australia

Emergency Department Consultations: the Complexity of Ethnographic and Discursive Representation

This paper examines emergency clinicians co-constructing knowledge about their patients. It examines how knowledge organises what clinicians do—their action—in the teleological spacetime (Schatzki 2009) configurations of bedside consultations in five, Australian Emergency Departments (EDs). Presenting findings on the discursive and clinical practices of emergency clinicians, their interprofessional networks and ‘situated knowledge practices’ (Gherardi 2008) at patients’ bedsides, I examine a unique empirical data set integrating aspects of the discourse of the consultation with the spatial, disciplinary and organisational contextual variables that impact on clinician-patient interactions. These consultations are situated within an extensive body of ethnographic and discourse data comprising 200+ hours of non-participant ethnographic observation, 160 clinician interviews and 81 audio-recorded clinician-patient consultations.

Findings show this institutional medical encounter as a dynamic, disrupted and fragmented discourse event, characterised by sequential clinician interactions, often propelled more by institutionalised, professionally-sanctioned protocols and practices and material arrangements—artefacts and spatiality—than by the recognised turn-taking conventions and sequence processes of dyadic medical consultations. By showing the broad relationship between the macro-context of healthcare, the meso-context of the ED and the micro practices of communication, I discuss the challenges of analysing and representing the ethnographic and discursive complexity of the ED consultation. I argue that it is important to capture fully ‘what goes on’ – ethnographically, linguistically and organisationally – in the ED consultation, as it is in combination, not in isolation, that these elements challenge sensemaking for patients and clinicians alike.

Maureen Matarese

BMCC, City University of New York, USA

Dynamic Discourse: Time Talk in Caseworker-Client Interaction

Responding to increasing homelessness, New York City's homeless services initiated their strategic plan in 2004 (DHS, 2002, 2004). One initiative required shelter caseworkers to place clients into housing in nine months or less, a process facilitated by caseworker-client interaction over time. Meeting this initiative was particularly challenging for undocumented clients who lacked legal income and could therefore not receive housing through the city.

The health interaction field often uses qualitative, discourse-based research to examine practitioner talk (Erickson, 1999; Cicourel, 1999; Hall, Slembrouck, & Sarangi, 2006; White & Stancombe, 2003). Such studies highlight micro-linguistic intricacies of social work/health communication, but largely pose research questions that analyze snapshots of talk, overlooking contexts involving cumulative interactions over time.

This presentation describes a nine-month linguistic institutional

ethnography of caseworker-client interaction in a NYC homeless shelter, specifically highlighting caseworker-client talk over time in light of time-based policy initiatives. Using Nexus Analysis (Scollon & Scollon, 2004), a methodology combining ethnography, discourse analysis, and Lemke's (2002) timescales, this paper describes the policy-related timescales that one caseworker discursively constructed with three homeless clients (a short-term client, a long-term client, and a short-term undocumented client) over time. Findings reveal that the caseworker's discourse shifts dramatically over time with the long-term client. The caseworker also discursively treats the undocumented client like a long-term client due to time-based challenges she expects to face in housing him. This paper argues for analyzing institutional discourses cumulatively, highlighting the dynamic and evolutionary nature of discourse. Conclusions discuss implications for policy and practice.

Jemina Napier; Trevor Johnston; George Major (presenting author); Lindsay Ferrara

Macquarie University, Australia

Medical Signbank: Bottom-Up Sign Language Planning and Development

Background/objective: Researchers have identified the various challenges that can occur when interpreting for medical encounters (e.g., Angelelli, 2004; Dysart-Gale, 2005). Linguistic, cultural and educational impediments in the effective use of signed language interpreters in healthcare delivery have been identified by Australian researchers (e.g., Napier & Cornes, 2004), but until 2008 no linguistic research had been carried out on Australian Sign Language (Auslan) interpreter-mediated healthcare delivery. In this paper we will describe an Australian project* in which we facilitate an effective, accepted and shared sign language vocabulary for the discussion of medical and mental health issues by deaf clients and health professionals, mediated through Auslan interpreters. The conceptual framework for this project is language planning and development within a small linguistic community of 'limited diffusion'.

Data and method: This multi-method project involves the development of a web-based interactive multimedia dictionary and database of Auslan, along with online surveys and face-to-face focus groups – analysed using N-Vivo Discourse Analysis software—with interpreters, deaf people and healthcare providers.

Findings: The paper will outline the progress of the project, and specifically report on preliminary findings from focus groups conducted with deaf people and interpreters about the strategies they use to deal with medical terms that have no Auslan equivalents, and their thoughts on challenges in medical interpreting

Implications: We intend to 'turn the tables' on language planning and standardization—from 'top down' to 'bottom up'—and, by so doing, to encourage an organic and natural process of language development.

Catherine O'Grady

Macquarie University, Australia

The Accomplishment of Empathy in General Practice Consultations

Background: Empathy is a salient theme that animates discussions of clinical communication within the profession of General Practice. It is tied empirically to the achievement of improved clinical outcomes, considered as central to patient-centred care, and is a key construct in teaching and assessing clinical communication. Yet few studies have examined the interactional achievement of empathy in situ in specific situations and the effects of this accomplishment on the trajectory of a consultation.

Method and objectives: Drawing about ethnographic data, including interviews with medical educators and examiners and observations of training, this paper considers how empathy is conceptualised within the profession of General Practice. Drawing upon close

analysis of the discourse of two transcribed video recorded consultations, it sets out to show how empathy may be collaboratively achieved or fail in the process of interaction.

Findings and implications: Findings suggest that empathy is a multimodal accomplishment and that a doctor's empathic formulations in concert with other semiotic means including gaze and body orientation can function pivotally to open up communication about matters of clinical importance or, conversely, enforce movement away from life-world issues that may have been of clinical significance. Finally, it is suggested that such discourse analytical studies may offer insights of value to the development of empathy training.

Linda Örvlöv

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In the Shadow of the Future: Issues of Control in Early-Stage Progressive Dementia

Aim: Many live independently with a dementia diagnosis for a considerable time. Although capable in many ways, their influence on future care is often limited, and we know little of their perspective. How do persons with early-stage progressive dementia diseases perceive of and cope with their future in the face of the evolving disease? To what extent and how do they maintain agency and control in relation to their future situation? What strategies are applied to maintain control, and what obstacles are perceived?

Methods: This explorative study is based on conversational data from a local self-help group in a small Swedish community. Audio-recordings were used for content analysis focusing on the dynamics of topical trajectories to capture “sense-making in its making”.

Findings: Findings involve issues of losing control and lacking control. The first has to do with the course of the disease and its (manifest and expected) consequences in everyday life; the second with participation in planning and decision-making. These dimensions are interwoven both in the way issues of control are perceived and in strategies for handling them. The participants reflect discerningly on their condition and its consequences regarding safety, dignity and the burden of their next of kin as the disease progresses, and wish to take action before being incapable. At this early stage, however, they are not considered ill enough. Paradoxically, in an incisive wording, they lack the control to make arrangements to be able to give up control before losing control. Implications are discussed for dementia care-planning.

**Anthonia Palmer; Felix Chukwuneke; Thecla Ezeonu
(presenting author)**

University of Nigeria Teaching Hospital Enugu, Nigeria

*Routine Antenatal HIV Testing in Nigeria: An Overview of the Ethical
and Human Right Implications*

It is generally believed that HIV/AIDS is the most formidable pathogenic diseases to confront modern medicine. Many patients have been subjected to several kinds of humiliation and stigmatization within the communities they live because of their HIV status. Despite all the awareness being created everyday to stop social stigmatization, many people still found it difficult associating with HIV/AIDS seropositive individual. Consequently, most people do not accept routine HIV screening because of the uncertainty of the outcome if tested positive. In Nigeria, the societal attitude towards HIV infection, lack of advanced technique in prevention and the limited options of treatment when infected are vicious chain of reaction of events preventing voluntary testing. Several countries have their rules regarding HIV screening, while some recommend a

routine screening and in certain cases quarantine those tested positive, others are of the opinion that screening should be optional since compulsory testing will be an infringement on persons autonomy on issues concern one's health. However, in pregnant women the issue of routine testing appears more controversial because the health of the child in the womb is usually considered since the child can not make its own decision. There is a need therefore to determine the status of the mother so that treatment procedures will be initiated at early stage which will help not only the mother but also prevent transmission to the unborn child. This paper is an overview of the ethical and human right issues involved in routine HIV screening for pregnant women in Nigeria.

Gunn Pettersen₁; Jan H. Rosenvinge (presenting author); Rolf Wynn

University Hospital, Northern Norway₁

Professional Confidence as an Output of an Interdisciplinary Educational Program on Eating Disorders

Focus: This study focuses on impacts from an interdisciplinary educational program on eating disorders. Apart from raising the individual clinical competence among health professionals treating patients with such disorders, the aim was to raise the understanding of and practice of interdisciplinary work and system-based competence in building professional network groups.

Participants : 207 participants were encouraged to describe up to 12 possible scenarios depicted as prospects for their future work within the field of eating disorders.

Main findings: Analysing and sorting of the scenarios provided five categories that described the working situations the participants would prefer, i.e. 1) prevention/health promotion, 2)

interprofessional work 3) organisation of the health care system, 4) treatment, and 5) further developing of competence.

Discussion: The findings indicate that the program stimulated proactive disseminations subsumed as professional confidence. This term is, and should be highly related to clinical competence. Giving the increasing dissemination of factual knowledge of varying quality from multiple sources, both capacities may buffer both the uncritical or overly critical clinical use of factual knowledge. Further studies are needed to explore how confidence and competence may evolve, how they are interrelated, and how educational programs in psychiatry may promote them.

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Pushing Nature's Boundaries?: Weighing PGD for BRCA 1/2

Background/objective: Advancements in genomic medicine and assisted reproductive technologies present the opportunity for women at risk for Hereditary Breast and Ovarian Cancer (HBOC) to avail themselves of medical innovations designed to prevent passing on the BRCA1/2 mutations to their children. One such technology, Preimplantation Genetic Diagnosis (PGD), requires that a woman undergo in-vitro fertilization. The decision to make or not make use of PGD, an evolving technology, raises psychological, moral, financial, and existential issues.

Data and method: Semi-structured interviews exploring BRCA1/2 carriers' attitudes towards PGD and Prenatal diagnosis of BRCA1/2 mutations were conducted at a New York City cancer-treatment center. The majority of the participants were women. The interviews (N=31) were transcribed verbatim and coded using grounded theory methodology.

Findings: Emerging themes from this research indicate tensions within and across participants regarding PGD. PGD offers the hope of a breast and ovarian cancer-free life for their children. At the same time, PGD conflicts with notions of "nature" and "natural" that BRCA1/2 mutation carriers bring to the PGD decision-making process. This paper will discuss: 1) the way in which participants talk about PGD as conflicting with their desire to conceive "naturally" and 2) the way in which participants construe choosing embryos through PGD as disrupting nature, leading down a "slippery slope" towards designer children.

Implications: The results of this research will help inform health practitioners of the issues that BRCA carriers bring to bear when considering PGD for the mutation. This knowledge can be useful when discussing PGD with patients.

Pamela Poe

Manhattan College, USA

Direct-to-Consumer Prescription Drug Ads in the US: A Qualitative Study of Older Adults Using Grounded Theory to Study DTC Ad Response

Background and Objectives: Direct-to-consumer (DTC) prescription drug ads, while banned elsewhere, have been permitted in the United States since 1997. Nearly ten years after allowing DTC ads, this study focused on older adults as increasing pharmaceutical company marketing targets. Participants were asked about selected print ads, specifically detected health information and marketing.

Methods: Qualitative in-depth interviews were conducted in four suburban Pennsylvania settings with twenty-five women aged 65-90. The women were asked to comment on twelve magazine ads featuring prescribed remedies to treat a range of illnesses. The resulting data were coded and analyzed using grounded theory methods.

Findings: Results revealed that participants perceived DTC ads in

relation to four areas of social and/or media interaction. These “health media filters” included their own healthcare, the experiences of others in their social network, prior healthcare provider recommendations, and prior health-related media exposure. Patterns of trust or lack of trust in clinician recommendations and pharmaceutical companies as information providers also emerged.

Implications: The findings suggest that for older adults in the U.S., exposure to DTC ads may affect health literacy levels evident in such areas as treatment compliance, trust in clinician recommendations and drug company awareness. Future research might study aging adult responses to other health media, older adult male response to DTC ads, or younger adult media consumption of DTC ads in such venues as web-based banner ads.

Maria R. Dahm

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*'I Can Understand It Is Really Difficult' - Challenges Faced by
International Medical Graduates in Australia*

Background/objective: Many western nations including the United States and Australia have become increasingly reliant on international medical graduates (IMGs) as an important part of their medical workforce. In Australia, these recruits come from a range of cultural and language backgrounds, and often received different medical training from their Australian colleagues. These factors put additional strains on IMG-patient communication. This exploratory study investigates the various challenges that IMGs face as they prepare to enter the new medical environment.

Data and method: Data were collected in the form of semi-structured interviews and observations conducted at a medical language bridging course for IMGs. All interviews were audio-recorded and transcribed. During the classroom observations fieldnotes and comments were gathered and later enhanced by adding reflective thoughts. All data were analysed through reiterative open coding to let themes emerge progressively (Strauss & Corbin, 1998).

Findings: IMGs are faced with numerous cultural, linguistic and systemic challenges once they decide to enter Australia's medical workforce. Most doctors experienced problems due to their unfamiliarity with the Australian medical system. Particularly, the demands of patient-centred care were new for many IMGs, and in relation to their cultural and language backgrounds created confusion and various communication difficulties.

Implications: This exploratory study has identified some of the most common difficulties for IMGs with no previous experience of a Western (Australian) medical environment. It suggests that IMGs will benefit from tailored preparation prior to entering the workforce. Participation in comprehensive training courses in which recruits acquire strategies for patient-centred communication could strengthen their consultation skills and thus ameliorate IMG-patient communication.

**Guitlee Rahill; Maria Aysa Lystra; Mario De La Rosa;
Elizabeth Buffington O'Neil**

Arkansas State University, USA

*Cultural Adaptation of a Survey Instrument for Use in HIV Knowledge
Research on a Rural Southern U.S. University Campus*

The cultural adaptation of instruments used in social science and health research has been an important issue, particularly with respect to Latinos, Haitian and other U.S. immigrants, and to HIV research. Less is known about the adaptation of research tools for use with non-racial, non-ethnic or non-immigrant minorities, such as underserved and underrepresented residents of the rural south. We assessed the utility of a survey instrument for use in research with rural University students in the Mississippi Delta. The survey was previously used to explore the relationship between HIV Knowledge, HIV Stigma, Religion, Substance Use and Sexual Risk Behavior in a sample of urban university students. In a focus group of eight (8) students of varying race, ethnicity and gender, we set out to evaluate the cultural and

educational utility of the survey, and to identify potential barriers that could arise when conducting research with students at rural universities. Participants were selected through a purposive targeted sampling method. A content analysis of the focus group data was supported by ATLAS.ti 6.0 ®. Results provide valuable insight into the cultural nuances that may be specific to conducting health research with rural residents and with students matriculating at rural universities in the U.S. Implications are that the language and phraseology of research tools must be adapted even within the same English language. If we are to elicit the most useful HIV related health data, cultural and linguistic adaptations must consider the cultural and religious context, even when residents are English speaking.

Helen Rasmussen

**Human Nutrition Research Center on Aging at Tufts
University, USA**

*Photo Elicitation in Health Care: Exploring Perceptions of Health,
Happiness and Trust in Elderly Men and Women*

Background and methods: As part of a 3-phase, mixed methods (QUAN → qual) study of how the collective construct of social capital (SC) and individual social networks (SN) influence health and well being, elderly (>60 years) men and women participants were given disposable cameras and were asked to photograph their daily routines. Using participant's photographs as visual cues and prompts, participants were interviewed to provide context and clarification to their SC (Social Capital Benchmark Survey), SN (Lubben Social Network Scale), and health questionnaire (SF-36) responses.

Findings: Participant responses to SC dimensions of health, happiness, and trust are presented as composites of the SC survey, SN and SF-36 questionnaire and photo elicitation (PE) interview.

These PE-driven interviews provided enriching, surprising and often contradictory meaning to the composite survey and questionnaire responses, highlighting a need for clarification of questions relating to self-assessment of health status on survey tools. An unexpected finding was that all participants reported distrust (of varying levels) in their personal health care provider.

Implications: A PE interview exploring the daily routines of an elderly man or woman is a useful, efficient, and thorough method of capturing health-related behaviors as well as areas of medical noncompliance. PE provides visual and emotional cues that encourage active engagement from participants in the data collection process and can facilitate and enrich interpretation of study data.

**Kathryn Rugen; Laura Szalacha; Anita Kinney; Rhonda Belue;
Usha Menon**

Jesse Brown Veterans Affairs Medical Center, USA

*Computer Tailored Intervention in Primary Care to Promote Colorectal
Cancer Screening*

Background/objective: Despite the known morbidity and mortality benefits of early screening for colorectal cancer (CRC), screening rates remain sub-optimal for adults.

Data and method: In this RCT, we compared completion of any CRC screening test post-intervention between groups receiving a minimal intervention or a tailored intervention (TIMS). TIMS is computer-based questionnaire plus tailored messages on beliefs and knowledge related to CRC and screening. Data were collected during 2006-07 in primary care clinic waiting rooms at two Midwestern medical centers. Reliable and valid scales were used to assess CRC knowledge and beliefs.

Sample: Participants (N = 199) from primary care clinics with a mean age of

56.4 (SD 6.8). The majority were African American, male, had some college education and health insurance.

Findings: Although both study groups showed significant improvements in knowledge and beliefs, there was no significant intervention effect. Only past screening (OR = 3.3, CI = 1.1–10.7) and physician effect (discussion of risk/screening) (OR = 1.5, CI = 1.0–2.3) significantly predicted post-intervention screening. Barriers decreased significantly from pre- to post-intervention in both groups.

Implications: The results of this study underscore the need to further test the impact of health care provider recommendation and communication with tailored interventions on CRC screening.

Gabriella Rundblad; Olivia Knapton

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Communicating Safe Behaviour to the General Public: A Comparison of the Different Stages of a Natural Disaster

Background/objective: In 2007, 340,000 people in Gloucestershire, England lost their drinking water for up to 17 days during the worst ever floods to hit the UK. Once water was restored, consumers were issued safe drinking water advice. A recent questionnaire study revealed a high degree of non-compliance to official advice. This study aimed to reveal how various discourses reflected official advice during the different stages of the incident and how they may have affected consumers' perception and behaviour.

Data and method: Written media reports and advice from official sources were compiled into a corpus, which was sub-divided into four incident stages. Corpus linguistic analysis and manual cognitive discourse analysis were employed. Analysis was supported by questionnaire results, interviews and focus groups.

Findings: Local media was more tuned-in to public needs and consequently

more utilised by consumers. While national coverage rapidly decreased as the floods became manageable, local coverage was more consistent across the stages, including reporting when the drinking water was safe. In the initial stages of the incident, lack of clarity when referring to different types of water and different authorities may have hindered advice comprehension and thus reduced compliance. Although the choice of information source used did not directly impact consumer behaviour, we did find that a simultaneous change in local and national media towards more authoritative language corresponded temporally with a decrease in non-compliance.

Implications: Emergency plans for natural disasters must consider improvements to consistency, accuracy and accessibility of various advice sources in order to maximise public uptake of the recommended actions.

Hanne Rustad

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Norway**

*Intensifiers as a Strategy for Communicating Health Risk and
Normality Concerning Cardiovascular Diseases*

Objective and background: The paper explores how potential worry for health risk is communicatively dealt with in eight doctor-patient consultations as part of a health study. Risk communication can be explored at different levels, such as in the public domain or in consultations. The focus of this paper is on the micro-level, investigating how “intensifiers”, words that serves to intensify the meaning of a word or phrase, are used to normalise and reduce potential worry. Drawing on Bredmar & Linell (1999) the paper will show how intensifying utterances such as “perfectly normal” are used by the GP as a risk communication strategy. The patients have volunteered in a health study. The results from the study, given in a standardized letter, indicates that they need to consult their family doctor for further advice. The letters provide

risk information, which become assessed in the consultation.

Methods: The consultations were audio-recorded and transcribed. Extracts were selected to show examples of the GP talking about patients’ health risks. The paper will explore how the doctor communicatively deals with potential worry for risk from a detailed discourse analytical viewpoint.

Findings and relevance: The GP frequently used intensifiers when examining the patient’s medical results. Intensifiers were used particularly concerning results that showed normality as opposed to results implying potential health risk. The doctor’s use of intensifiers can be explained in relation to the health study the patient’s have participated in.

Somnath Saha₁; Mary Catherine Beach₂

Portland Veterans Affairs Medical Center, USA₁, Johns Hopkins University, USA₂

Physician Patient-Centeredness and Patient Decision-Making: A Randomized Study Using Video Vignettes

Background: There is limited evidence as to whether physicians' patient-centered behaviors are associated with outcomes other than patient satisfaction.

Methods: We developed video vignettes with actors portraying physicians, discussing options for coronary heart disease (CHD) management with a patient/actor, and recommending coronary artery bypass graft (CABG) surgery. For each actor, we produced 2 vignettes. In the first (high patient centeredness), the physician invited more patient participation, was more emotionally positive, used simpler language, gave more information, expressed more empathy, and used more eye contact than in the second (low patient centeredness). Both vignettes contained the same information about CABG risks and benefits. We randomized patients to view one vignette. Outcomes were patients' stated likelihood of undergoing

CABG if they were the patient in the video (1 item, score 0-3); perceived necessity of CABG (1 item, score 0-5); likelihood of seeking a second opinion (1 item, score 0-3); ratings of physician competence (4 items, score 0-4); and trust (10 items, score 0-4).

Findings: Of 335 eligible patients, 248 (74%) completed the study. Patients viewing the high patient-centeredness vignette were more likely to say they would undergo CABG (2.54 vs. 2.01, $p < .001$) and rated the necessity of CABG higher (4.21 vs. 3.60, $p < .001$). They rated patient-centered physicians as more competent (3.22 vs. 2.66, $p < .001$) and trusted them more (2.93 vs. 2.28, $p < .001$) but were not less likely to want a second opinion (2.22 vs. 2.40, $p = .14$).

Implications: A patient-centered orientation may improve not only patients' satisfaction but also their willingness to accept medical treatments.

Somnath Saha₁; Todd Korthuis; Victoria Sharp; Jonathan Cohn; Richard Moore; Mary Catherine Beach₂

Portland Veterans Affairs Medical Center₁; Johns Hopkins University, USA₂

Physician Interracial Anxiety, Communication, and Satisfaction among Patients with HIV

Background/objective: Racial disparities in interpersonal care are often attributed to cultural differences between patient and physician but may also be caused by discomfort when interacting with members of other racial groups. This “interracial anxiety” has received little attention in health care communication research.

Data and method: We enrolled 45 physicians and 331 nonwhite patients at 4 HIV clinics in the U.S. Physicians completed two scales measuring interracial anxiety with black patients (12 items, $\alpha=0.83$) and Latino patients (12 items, $\alpha=0.86$). Patient-physician encounters were audiotaped and coded using the Roter Interaction Analysis System. In post-visit interviews, patients reported on physicians’ communication and rated their satisfaction. We tested associations of physician interracial anxiety with selected physician communication behaviors, affect and verbal dominance, visit length, patient reports of physician communication, and patient

satisfaction, adjusting for patient and physician age and gender, and physician race, and accounting for clustering of patients within physicians

Findings: Physicians were predominantly white (69%) and Asian (24%); patients were primarily black (77%) and Latino (19%). Physician interracial anxiety was associated with fewer information giving statements (incidence rate ratio 0.87, 95% CI .78 to .98), less verbal dominance ($\beta=-0.18$, 95% CI -0.30 to -0.07), and lower patient satisfaction ($\beta=-0.17$, 95% CI -0.19 to -0.05). Interracial anxiety was not associated with other communication outcomes or visit length.

Implications: Physician interracial anxiety had detectable effects in encounters with black and Latino patients. Interracial anxiety, a concept distinct from cultural differences, might be a relevant target for interventions to improve physician interactions with minority patients.

Srikant Sarangi₁; Chris Butler

Cardiff University₁, UK

The Burden Of (Non) Treatment: Offline Commentary During Physical Examination in Primary Care Consultations

Discourse/conversation analytic studies of primary care consultation predominantly focus on the different stages of the primary care consultation, e.g., symptoms presentation, history taking, delivery of diagnosis and negotiation of treatment. With regard to the physical examination phase, which has received relatively less attention, Heritage and Stivers (1999: 1501) identify the occurrence of ‘online commentary’ – defined as ‘talk that describes what the physician is seeing, feeling or hearing during physical examination of the patient’ (see also Mangione-Smith et al 2003). Online commentary, according to these studies, pre-empts possible resistance on the part of patients if it were to be a ‘no-problem’ diagnosis.

This presentation complements and expands this line of enquiry, based on audio-recordings of 24 primary care consultations concerning upper respiratory tract infection (URTI) of children. First, through thematic and interactive mapping of the

communicative trajectories during physical examination, the following six nodes are identified: online commentaries, directives concerning modes of examining, relational rapport, interpretive summaries, indications of potential diagnosis, and general explanations about causation and (non)treatment. We then focus on the occurrences of general explanations – labelled as ‘offline commentary’ – which point to the co-existence of the doctor’s therapeutic role as dispenser of (non)treatment and his/her pedagogic role as patient educator. We may suggest that shifts between online commentaries, offline commentaries foreground the doctor’s pedagogic role, while positioning the parent as an expert and spokesperson for the children. In paediatric consultations both online commentaries and offline commentaries function rhetorically in anticipation of future action plans. It is anticipated that the findings will provide useful insights for medical educators and trainers of practitioners.

Benjamin Saunders

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“I Just Don’t Want to be Thought of as the Girl Who’s Ill”: Young Adults’ Construction of Others’ Perceptions in Accounts of Chronic Illness

Background: Research investigating young adults’ experiences of chronic illness has often focused on sufferers’ own perceptions of their condition, and the role illness plays in their lives (Brydolf and Segesten, 1996; Dovey-Pearce, Doherty and May, 2007). This paper will however explore sufferers’ views regarding the perceptions of others about their condition, such as friends, peers and colleagues, a theme which was found to be salient in the present research. It can be argued that others’ perceptions are especially important to sufferers of this particular age-cohort, given the importance they attribute to constructing an appearance of ‘normalcy’ when around others (Balfe, 2009).

Methods: The present paper forms part of a larger doctoral research project exploring young-adults’ experiences of living with chronic illness, using type 1 diabetes (T1DM) and inflammatory bowel disease (IBD) as case-studies. It will draw upon semi-structured

interviews (n = 30) with sufferers, aged 18-29. Extended data-extracts will be explored using discourse analysis to investigate how sufferers construct their experiences.

Findings: Respondents’ accounts demonstrate that the views of others play a significant role in whether sufferers are able to construct the desired identity of ‘normal’ young-adult, with regard to age-appropriate behaviours. Sufferers’ views regarding whether others saw them as someone who has an illness appeared to affect how they construct their own relationship with their condition.

Implications: This research aims both to contribute to the field of discourse-analysis, whilst also having implications for the healthcare provision regarding this age-cohort.

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Appealing to the Authority of the Many in Direct-to-Consumer Advertising: an Argumentative Perspective

In recent years, direct-to-consumers advertising (DTCA) has become an issue of controversy between those who support and those who oppose allowing it in Europe. In this paper, we examine the appeals to the authority of the many in DTCA. In spite of the importance of the opinion of the masses, the appeal to them, often found in DTCA, is not necessarily always reasonable. Unreasonable appeals can be deceptive to the consumers, urging them to press doctors to prescribe unnecessary prescription drugs. The appeal to the masses is examined from an argumentative perspective, aiming to establish criteria that distinguish the reasonable appeals from those that are unreasonable and thus deceptive. From this perspective, appeals to the masses are viewed as a type of argument by means of which a party, pharmaceutical companies in the case of DTCA, tries to convince another party, consumers in

the case of DTCA, of the acceptability of a claim, that consumers should ask their doctors to prescribe a certain medicine. We start from the assumption that the characteristics of the special context of DTCA play a significant role in the judgment of reasonableness of this type of argument. Based on the examination of a sample of ads published in the Time and Good Housekeeping magazines, and of the available literature on DTCA, we characterise the communicative practice of DTCA as a particular argumentative activity type (van Eemeren and Houtlosser 2005), in order to highlight its aim and the means to reach this aim given the rules and conventions that regulate it. Such a characterisation provides a detailed picture of direct-to-consumer advertising, and is thus useful for properly identifying the strategic function of the appeals and establishing the criteria for evaluating them.

Christoph Schweikardt

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Mobile Phone Health Risk Messages in the Context of Political Debate on Precautionary Measures in Germany

Background/objective: The rapid extension of mobile phone communication led to increasing concerns about associated health risks. Therefore the so-called “German Mobile Telecommunication Research Programme” was launched, starting in 2002 and ending in 2008. Simultaneously, a controversial political debate focussed the alleged need of legislative precautionary measures. This paper elaborates on the health risk messages that were tailored during the decision-making process.

Data and method: Publications of main actors across the political spectrum and debates in federal parliament were analyzed with regard to positioning and argumentation strategies.

Findings: Left-wing opposition parties aimed at being perceived as advocates of worried citizens. They stressed remaining uncertainties and emphasized the need for further precautionary measures such as lowering the specific absorption rate (SAR) limit and

mandatory SAR-labelling of mobile phones. They referred to studies that found a certain risk of health impairment, and stressed that health matters should be ranked higher than economic considerations in a state of uncertainty. The Federal Office of Radiation Protection, government and governing parties aimed at reassuring the public, that research results showed no evidence for health risks, provided, that current limit values were observed. It also concluded that further investigations on the effects on children and long-term effects had to follow. Precautionary measures minimizing electromagnetic field exposition should be taken individually. Thus, opposition motions were rejected at large.

Implications: Supposed health risks build up powerful public arguments. Competing risk messages relied on different value hierarchies and interpretations with few chances of consensus in the foreseeable future.

Azizi Seixas

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"Risky" Business: Understanding, Investigating and Communicating Risk in Youth Delinquency

What is a risk factor? According to DeMatteo & Marczyk (2005), risk factors are defined as “external or internal influences or conditions that are associated with, or predictive of, a negative outcome (such as delinquency or antisocial behavior)” (DeMatteo & Marczyk, 2005, pp. 20-21). In social science research, the discursive usage of “risk” factors take on a wide range of connotations, such as epistemological, political and social meanings. The paper will initially explore and critique the positivistic epistemology of risk factors embedded in social scientific research and theory. Borrowing from the insights of Case and Haines (2009), the paper will identify three epistemological flaws with this approach: determinism, imputation and reductionism. The paper will then explore the social and political implications of risk factor studies, primarily focusing on how risk factor

research is communicated to and understood by the public and how it affects public policy, in the United States.

The second section of the paper will illustrate the above-mentioned points through the example of risk-based etiologies and theories on delinquency, in criminological research. Specifically, this section of the paper will identify the epistemological, political and social connotations of risk factors in delinquency research. Through this example, the paper will argue that the proliferation of “risk” factor research is risky business in trying to understand and curb rampant rates of delinquency, particularly for racial and ethnic minority youth in urban areas. The paper will show that the over-emphasis on risk factors in theory, research and policy is “risky” business.

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McGregor**

University of Technology, Sydney₁, Australia

*Achieving Effective Clinician-Patient Communication in Hospital
Emergency Departments*

The growing number and complexity of presentations to hospital emergency departments (EDs) is increasing the 'work' that communication is required to do in this context. The possibility of communicative discontinuities, misunderstandings and breakdowns is on the rise.

In this paper we present and discuss some of the findings of a three-year project in five EDs in Australia that involved recording, analysing and describing clinician- patient interactions through the ED from triage to disposition. The research used a qualitative ethnographic approach with detailed communication analysis. By combining these methodological approaches it has been possible to analyse how talk is socially organised around health care practices and how language, organisational, disciplinary and other contextual factors impact on the effectiveness of communication.

Through detailed analysis of audio-recorded interactions we analyse the 4 sequential, goal-oriented stages patients move through in the ED. These stages—triage, admission, history-taking and examination, and finally diagnosis/disposition—display distinctive communicative features. We describe the communication features typical of each stage, examining how these position patients and simultaneously enable and constrain clinicians.

Although the staged and disciplinary structure of care impacts on both interactants' opportunities to engage effectively, we propose that successful communication in this context can still be achieved through a balance between: 1) establishing and communicating a timely and accurate medical diagnosis, and developing a management and/or treatment plan; and 2) building an interpersonal relationship with the patient. The paper discusses a range of communication strategies clinicians use to achieve this balance.

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Health Communication and the Internet: An Analysis of Adolescent Language Use on the Teenage Heath Freak Website

Background: This paper will report on the findings of a collaborative study examining the communicative strategies of adolescents in computer-mediated health care communication. Recent technological advancements have resulted in the emergence of professionally-run online health communication forums and one such UK-based website entitled Teenage Health Freak provides the unique opportunity to analyse the different styles and registers that adolescents chose to express their health concerns.

Data and Methods: This project combines the expertise of linguists and general practitioners working on data taken from a 4 million word longitudinal corpus comprising messages written by adolescents about their health concerns to request medical advice from a qualified general practitioner. A variety of tools and techniques taken from computerised textual analysis, including corpus linguistics, are applied to the

data set in order to identify specific linguistic patterns of usage.

Findings: The findings include valuable insights into how adolescents articulate representations of their own bodies through their selection of particular registers and written styles, including the use of slang and taboo language. The electronic forum provides a medium of communication for adolescents where their identities are anonymous, enabling them to articulate their health care concerns on topics that may cause embarrassment and/or a lack of disclosure if discussed face-to-face.

Applications: The paper will conclude by reporting upon the production of an encyclopaedic resource designed to be of practical benefit to health care practitioners working with young people, as well as being a resource for parents, educators and adolescents themselves.

**Jeffrey Solomon₁; Gemmae Fix₁; Ellen Cohn; Dharma Cortes;
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**Center for Health Quality, Outcomes, & Economic
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*How Patients and Providers Negotiate Problem-Solving During Clinical
Encounters: The Role of Speech Registers*

Background/objective: During clinical encounters, many types of problems arise that providers and patients seek to resolve. Problems might include, for example, attempting to describe or understand elusive symptoms, determining next steps for investigating the nature of patient symptoms, and, among others, discussing the practicality of certain medication regimens. Our objective is to describe how providers and patients use various speech registers—broadly defined as speaking styles—to negotiate solving problems.

Data and method: As part of a larger study that investigated communication in clinical encounters, we audio-recorded interactions between providers and patients. Out of 52 interaction transcripts, problem-solving negotiation occurred in 13. We conducted discourse analyses of problem-solving text segments across the 13 transcripts to identify patterns of register use.

Findings: There were 11 cases in which a problem was at least provisionally resolved. In 4 cases, providers almost exclusively used a biomedical register, while patients used a “lifeworld” (Schutz, 1973) register. Problems were coded as resolved when patients indicated at least partial assent to providers’ proposals. In 5 cases, providers alternated between biomedical and lifeworld registers, while patients adhered to lifeworld registers. Problem resolution in these cases entailed patients’ assent to provider suggestions, however providers also demonstrated uptake of patients’ lifeworld concerns.

Implications: Our findings suggest that there are varying patterns of negotiating and resolving problems during clinical encounters. In some situations providers’ use of a biomedical register is effective, while in others providers’ use of both biomedical and lifeworld registers are more effective for negotiating problems.

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Opioid Prescribing for Chronic Pain: Reflections on Shared Decision-making

Background and Objective: Chronic Noncancer Pain (CNCP) is a common medical problem. How providers and patients make decisions about treating it is poorly understood. We examined what rural primary care providers and patients thought about treating CNCP with opioids, and how the social and regulatory context affected the decision-making process. The objectives of this study were to 1) Identify features of opioid prescribing that influenced decision-making; 2) Understand how social forces influenced patient and provider beliefs and ability to engage in Shared Decision-making (SDM) and; 3) Examine how theories of SDM might be revised.

Methods: We conducted semi-structured, in-depth interviews with convenience samples of 14 providers and 24 patients. These were transcribed and analyzed using grounded theory

techniques. We examined the findings to understand how they related to SDM.

Findings: Lack of congruence in conceptions of CNCP and fears about deception led to patient - provider conflict. Patients wanted to be listened to, and their pain to be recognized as physical. Providers questioned whether to trust their patients' reports of pain. In response to these uncertainties providers emphasized the need to unilaterally set the agenda for clinical encounters and control prescribing.

Conclusion: This study illustrates how social and institutional forces acting in a complex context led to prescribing practices which were in conflict with SDM. Conceptual models of SDM should be expanded to take these findings into account. Patients and clinicians should learn to communicate their beliefs explicitly to each other.

Adrian Stokes

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Is there Such a Thing as a ‘Teaching Style’, and Does it Matter?

Background: A number of inventories have been developed for use by health professionals to promote and structure their reflection on teaching. Typically, these tools involve a scoring mechanism and indicate a profile described variously in terms of ‘teaching perspectives’, ‘teaching approaches’ or ‘teaching styles’.

The issue to be explored

This paper explores the theoretical positions, conceptual frameworks and empirical evidence associated with inventories on teaching styles, approaches and perspectives.

Methods: The main method is critical appraisal of the theoretical and evidential aspects of the literature relating to inventories of teaching styles, approaches and perspectives, informed by professional experience of running medical education faculty development from novice to master’s degree level.

Findings: There is considerable conceptual variation and some

terminological confusion surrounding teaching styles, approaches and perspectives. The theoretical basis is not always clear and the apparent parallels with learning styles, approaches and perspectives need to be considered with caution. While the specific evidence-base would generally be regarded as weak considered against clinical evidential hierarchies, there nonetheless appears to be a general acceptance of the heuristic value of inventories as prompts to structure reflection.

Implications: These findings have implications for the role of ‘teaching styles’ inventories in faculty development. They raise ethical and pedagogical issues relating to the use of tools which lack an evidence-base but which have been found to have heuristic value. It is suggested that these tools have the potential to provide a tipping point in the progression from novice teacher to expert educator.

Roar Stokken; Johan Barstad

**Patient Education Research Center, Norwegian University of
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*Center Chalk and Cheese – Or Two Peas in a Pod. Challenges Posed
When Self-Help Becomes a Tool for the Public Health Care*

Self-care has gained strong interest and support from the Norwegian government, and the idea has been embedded into central documents (e.g. the Patients' Rights Act and the Special Care Act). In the Norwegian approach to self-care, patient educative initiatives have developed from being mere patient schools aiming at compliance, towards the more traditional self-care initiatives. Thus the distance between self-help and patient education can be argued to be shorter in Norway than in many other countries. At the same time this also blurs whether activities are to be considered as patient education or as self-help. This poses challenges to both hospitals and self help clearinghouses. Through a theoretically informed empirical approach we look into the commonalities among – and differences between – self-help and patient

education by investigating four projects: a preoperative information day at a hospital, an online self-management programme, a professionally led self-help group for obese and a 12-step initiative. All initiatives are examined from the perspective of leaders/mentors/seniors, focusing on the communicative elements such as information, networking and organizational adapting. We approach these as educative initiatives, through a three dimensional view of learning. Through this, we can both pinpoint processes at work in the four initiatives, and deduct features that distinguish self-help from patient education in the Norwegian context. Further our investigation in processes at work, contributes to a better understanding of the role of professionals in these initiatives.

Anne M. Storey

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*Displaying Professional Expertise in Medical Case History
Presentations in PBL Tutorials: A Discourse Analytic Study*

Background and objective: Case history presentations play a major role in medical work and are consequently a key feature of clinical education and an indicator of professional expertise. Throughout their medical training, students interview and examine patients and present their histories to medical tutors. One aspect of the case presentation that has seen little research is its role in problem-based learning (PBL), notably from a discourse-analytic perspective. In this paper I make use of the notions of activity type, unequal or asymmetrical roles, and front stage / back stage activity to generate an analytic framework to illuminate how the educational and professional demands of case presentations are continually managed discursively within the PBL tutorial. Through analysis of the discourse, the performance of participants in different roles provides cues to the nature of expertise.

Method: This paper draws on data taken from a small corpus of audio and video recordings of eight final year undergraduate PBL tutorials in clinical medicine, amounting to sixteen hours of

recording time. The tutorials were observed and recorded in side rooms off the hospital wards in which the students had interviewed the patients. The recordings were transcribed and partially coded to identify focal themes, and then analyzed using the above-mentioned analytic framework.

Findings: Through the analysis of the asymmetrical dynamics of the tutorial and the shifting foregrounding and backgrounding of participants' educational and professional roles, a complex picture emerges of how professional expertise is constructed through questioning from tutors and peers, the giving of explanations for diagnostic hypotheses, and the management of uncertainty.

Implications: This study makes a contribution to our understanding of the communicative challenges of medical education where expertise may rest not only in knowledge of the subject but also in management of the discursive demands of overlapping educational and professional contexts.

Laurel Stvan

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Stress Management: Corpus-based insights into Vernacular Interpretations of Stress

Background and objective: A linguistic case study of vernacular terms reveals contemporary speakers' health beliefs about stress, showing stress to be one of several polysemous terms where "lexical conflation" accounts for the intertwined over-literalization of the concepts involved.

While literature exists on stress (Meyerson 1994, Mulhall 1996) and on differentiating medical and colloquial senses (Ream & Richardson 1996), no semantic analysis exists of how lay speakers interpret the term stress.

Method: Two data sources were used: a general corpus of English (COCA--the Corpus of Contemporary American English) and a more genre-focused dataset from CADOH (the Corpus of American Discourses on Health).

Collocations were analyzed to examine the distribution of wordforms including stress, stressed, stressor, stress test, and posttraumatic stress disorder.

Findings: Results show that stress is portrayed as a source outside the body, an emotional state, and a physical symptom of the body.

Implications: A mismatch surfaces between the messages sent by health professionals and those re-circulated by the general public. The identical appearance of different senses can lead speakers to think that the same concept is being discussed, preventing a consistent interpretation of "stress reduction."

Deborah Swinglehurst₁; Celia Roberts; Trisha Greenhalgh

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Voice and Authority in the Electronic Patient Record

Background/objective: The EPR has been conceptualised as a “third party” in the clinical consultation. Despite widespread adoption of the EPR, and the importance attached to the therapeutic potential of the clinician-patient relationship, the complexities of the clinician-patient-EPR interaction remain underexplored. I draw on linguistic ethnography to illuminate this triadic relationship.

Data and method: I have conducted ethnographic observation of the EPR in two UK general practices, including video recordings and screen capture. Adopting a multimodal approach to transcription, I have mapped consultations focusing analytical attention on the EPR as both material and textual presence. Drawing on Goffman’s notion of participation framework and Bakhtin’s concepts of voice I explore the “EPR as participant”.

Findings: The EPR emerges as a site of ideological struggle, “multi-voiced”, and

an ambiguous authority, often bridging discursive territory between the particularities of the social encounter and a wider “institutional” voice. Authority may be discursively constructed through the clinician-patient-EPR triad, constituted by talk, bodily conduct and the EPR as “text”. The EPR brings the voice (and influence) of absent parties into the consultation and demands that we broaden our notion of what constitutes the “clinician-patient” interaction.

Implications: I extend previous work on the computer in the consultation by opening up the “EPR-in-use” to analysis. This is allowing us to build a sophisticated characterisation of the consultation as a triad, challenging taken-for-granted assumptions about the nature of the primary care consultation, the communication which takes place and the foundation upon which the “therapeutic potential” of the relationship rests.

Debra Swoboda

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Genetalk about Psychiatric Illness: Lay Understanding of the Genetics of Bipolar Disorder

New medical discoveries regarding genetic susceptibility to disease and the decoding of the human genome have increased public attention to genetics, and genetic testing for psychiatric diseases (i.e., Mark-C, Psynome, AssureGene) is now available. While layperson understanding of genetics and genetic testing has been examined in individuals with common chronic diseases, few studies have addressed lay understanding of psychiatric illness and the new genetics. To address this gap, a study was conducted to investigate individuals' understanding of genetic risk factors for bipolar disorder and their beliefs about inheritance, upbringing, and cultural markers of illness. Twenty two semi-structured interviews were conducted with individuals who were diagnosed with bipolar disorder or who had a spouse, parent, or child diagnosed with bipolar disorder. Discourse analysis was used to evaluate transcripts, focusing on

subjects' rhetorical formations. Study findings indicate that while individuals explain susceptibility and inheritance at times in contrast with scientific constructs, they explain occurrence of psychiatric disease beyond simple geneticization. Participants have mixed feelings about genetic testing for psychiatric illnesses: they are concerned about the repercussions of labeling but welcome prediction of medication response and relief from blame. In addition, participants' genetic prognostication about bipolar disorder is bi-directional: knowledge of self is used to make sense of genetic identity, and vice-versa. Study conclusions raise questions about layperson understanding of the intersections between psychiatric illness, nature, and culture, and extend knowledge of possible psychological and social consequences of genetic testing to a condition not previously considered in depth.

Samina Syed-Afzal; Srikant Sarangi

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Communicating Visual Images: How Sonographers Frame Aspects of Risk and Uncertainty for Pregnant Women during Fetal Normality Ultrasound Scans

Risk and uncertainty routinely emerge as salient topics during most healthcare interactions and particularly so where knowledge about fetal health is paramount. Ultrasound scans conducted during different stages of pregnancy allow displays of high resolution images of the fetus that the parents have the opportunity to observe while the sonographer provides 'online commentaries' (Heritage and Stivers 1999) based on 'instructive seeing' (Peräkylä 2002). During this activity, parents sometimes volunteer clarification questions to make sense of what is not visible/intelligible. The topic of normality ('everything looks fine') recurs, evidenced by what can be seen.

Based on a corpus of over 50 recorded interactions involving sonographers and pregnant women and their partners in Northwest England, in this discourse analytic study we focus on sonographers' formulations of risk and uncertainty concerning both the fetus and the mother. We specifically draw on

Goffman's (1974, 1981) notions of frame and footing to identify shifts in relational talk and institutional/professional talk as the fetus is jointly talked about as a 'third party'.

Our findings suggest that sonographers routinely privilege the visual evidence in their accounts of normality and abnormality, in juxtaposition to pregnant women's initiation of topics of risk and uncertainty based on their experience of previous pregnancies. The sonographers confine their claims of (ab)normality within the expected stages of the gestation as the development of the fetus is an evolving form over the course of the pregnancy. In doing so, they align their formulations with the visual images that appear on the screen as a way of issuing reassurance wherever possible. We envisage that our findings have implications for sonographers' communicative practices in these highly sensitive settings.

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Contextualizing Pain and Endurance in Infertility Treatment and IVF

The current paper aims to explore women's contextualized experiences of the body and pain in infertility treatment. This is a specific situation, as the condition of infertility itself is usually not painful or symptomatic. Yet the treatment, undertaken voluntarily, creates pain and side effects with limited success rates, and thus has to be made meaningful. We conducted interviews with 17 women undergoing In vitro fertilization (IVF) infertility treatment in Bulgaria. The interviewing and analysis were informed by Interpretative Phenomenological Analysis. The transcripts were coded for emergent and superordinate themes, shared across the different transcripts. The main identified themes were:

Treatments/pain as cleansing and purifying; The body as mysterious, uncontrollable, damaging; Redefining bodily boundaries; Minimizing pain and

symptoms. The body was constructed as responsible for infertility and for its treatment, through a shifting between embodiment and disembodiment. The women narrated a distancing from the body and redefining of its boundaries, to endure pain for a meaningful purpose. At the same time, the disengagement from the body was fleeting and the painfulness of the procedures were both acknowledged and minimized. The sociopolitical changes in Bulgaria after 1989 have included shifts in values and meanings related to gender, the body and health. These include changes in social discourses regarding women's roles as mothers and the meanings of motherhood, children and childlessness. Women's experiences and meanings of the body and pain are grounded in gendered social discourses of responsibility for health, motherhood and childlessness.

Marianne Trondsen; Roar Stokken (presenter)

**Norwegian Centre for Integrated Care and Telemedicine,
Norway**

*Between Love and Technology – On Moderating Online Mutual-Aid
Groups*

Introduction: Since before the age of Internet, there have been e-mediated mutual-aid groups. In main these arise from fiery souls and mutual need. More lately, and due to the popularity of the Internet, online mutual-aid groups provided by organizations within public, voluntary and private sector also comes into being.

Objective: On basis of two diverse initiatives provided by organizations, we discuss how the role of the moderators is shaped by needs derived from the group and possibilities provided by technology.

Theory: The investigation is done by means of a theoretical framework developed from theories of communication and Science and Technology Studies (STS).

Material: The article draw upon two projects: One professionally led online self-help group conducted over two

years, and a lay-led online educative initiative conducted over eight weeks. The Self-Help Group is a service for adolescents with mentally ill parents. The educative initiative is the Norwegian online version of Chronic Disease Self-Management Program from Stanford University.

Findings: Within the Self-Help Group, the role of the moderator changed, and based on experiences there were decided to have a health professional as an available co-moderator in the forum. The Educative initiative is much more rigid in its form and technology offers a systematic, rule-based approach. While the Self-Help Group has great freedom and little is delegated to technology, greater parts are delegated to technology in the educative initiative. Consequences for the dynamics of the group in general and the role of the moderator in special will be presented.

Gala True

**Center for Health Equity Research and Promotion,
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*“I felt like an Alien.” Combat Veterans’ Reflections on Social Isolation
and Social Phobia*

Background: Nearly 20% of U.S. troops returning from combat deployments to Iraq or Afghanistan suffer from Post-Traumatic Stress Disorder (PTSD). Combat-related PTSD has been linked to social phobia among veterans resulting in social withdrawal and isolation, although the mechanism of effect is not well-understood. This paper reports on representations of post-deployment adjustment, social isolation and PTSD from a Life Story study conducted with combat veterans.

Methods: Fourteen veterans who had served at least one deployment in Iraq or Afghanistan and been diagnosed with PTSD or major depression met individually with the study investigator over 3-4 sessions to narrate their personal stories of military service. Life Story narratives were audio-recorded and transcribed. Transcripts were coded and analyzed using Atlas-ti.

Findings: Veterans’ narratives revealed insider perspectives on post-deployment social isolation and its impact on physical and mental health, family relationships, and work life. Veterans perceived that alienation and isolation immediately following demobilization intensified their PTSD symptoms. They also provided insights into factors that ameliorated or exacerbated their social isolation.

Implications: Veterans’ personal reflections on challenges to post-deployment reintegration enhance our understanding of how combat-related PTSD leads to social isolation and withdrawal. A potential area for future research is investigating whether sharing ones story with fellow veterans, loved ones, and healthcare providers results in decreased social anxiety and isolation for combat veterans.

Marisa Viale₁; José Carlos Gonçalves

**Research Group Discurso Interação e Práticas Sociais
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*Psychosocial Aspects of Adherence to Gynecological Assistance by
Women with Pathologies Leading to Uterus Colon Cancer in Rio De
Janeiro*

Background: This presentation reports a qualitative research model aiming at investigating aspects related to adherence to treatment through the analysis of interviews with women with pathologies leading to uterus colon cancer.

The observation of clinical experience in a high complexity care unit in the area of oncological gynecology, in the years from 2000 to 2006 led to the observation of dissociations between the objectives of the preventive exam and its perception by women.

Objectives: The research aimed at investigating this assistance hiatus observed at the secondary level of the assistance contract based on women's narratives.

Data and method: In the empirical research, fifty interviews were carried out, from which fifteen were selected for categorization, analysis and conclusion.

References from medical anthropology and discourse analysis were adopted in order to infer a possible users' position which differed from that of professionals.

Findings: The analysis models chosen turned out relevant for the description and analysis of the supposed and existing dissociations between the preventive examination and uterus colon cancer; between precocious infections and cancer; and between precocious infections and associated sexually transmissible virus.

Implications: These dissociations when not duly clarified at the secondary level of assistance may affect or inhibit asymptomatic women's adherence to proposed procedures, even when the treatment is of low cost and high percent of cure and supported by international protocols.

Alessandra Vicentini; Kim Grego; Paolo Bellini; Grazia Orizio; Barbara Berti

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Terminological Challenges in Medical Communication: Toward a dictionary of bioethics terms

The present paper proposal is the result of previous research conducted in the field of medical ethics and bioethics by a multidisciplinary team combining medical, linguistic (lexicographic, lexicological, translation, sociolinguistic), communicative and philosophical competences and research interests. As both a result and a development of this lasting cooperation, a new, long-term research project is under way, aimed at eventually producing a Dictionary of Bioethics Terms.

The analysis of different aspects of institutional medical-scientific communication, a multi-faceted subject personally affecting citizens, users and/or patients, has allowed to place a particular focus on the way new technological tools and globalising trends have rapidly changed its modes and canons, even producing phenomena of genre and language change / hybridisation.

In one such context, ethics – intended as that discipline both providing guidelines for practical behaviour in debated and controversial issues and allowing users/patients to access basic information about the subject they wish to learn about in a plain and simple format – plays a pivotal role, being interwoven as it is with communication, language and linguistic concerns.

Not only, such a pervasive topic, proving to be valuable from the viewpoint of academic study, but also from an applicative stance in those professional and institutional settings where the doctor-patient relationship is at issue, is currently posing new terminological and lexical challenges. Indeed, the emergence of novel modes of production and

frameworks and, consequently, the dissemination of medical information at different social levels – from the non-expert, updated daily by the media on the bioethical debate, to the professional/specialist, following the same debate through specialised channels – calls for both a redefinition and an updating of the lexicographic material available.

It is the aim of this study to present the background of the research and the plan of the work, laying out the methodological framework, the corpus and the target user groups.

In particular, the wordlists of existing dictionaries on ethics, bioethics and medical ethics will be firstly compared; secondly, general criteria of selection of potential headwords will be considered, paying attention to the prospective users and uses of a dictionary of this kind.

In order to establish the degree of acceptance and representativeness of the lexemes taken into account, the occurrence of some sample items in a corpus of written English will then be presented and discussed. Such a corpus is made up of the following digitalised texts: Universal Declaration of Human Rights, International Code of Medical Ethics, Declaration of Geneva and Helsinki Declaration – the four pillars of contemporary (medical) ethics.

It is finally suggested that corpora and IT tools should be exploited to develop statistically reliable criteria of inclusion or exclusion for possible ethical terms and to decide on their eligibility for a Dictionary of Bioethics Terms, in English, addressed to an audience of potential users from settings varying along

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*Towards Standard Setting for Clinical Communication Skills: Which
Criteria?*

Background: Overseas trained health professionals play an important role in filling health workforce shortages in Australia and most Western countries. Most registration authorities require some English language proficiency screening; however, such screening tends to be undertaken by language specialists using traditional linguistic criteria. It is rarely from the perspective of health professionals assessing whether the candidates possess the communicative competence to deliver safe and effective health care. This raises questions about whose standards and measures should be employed to screen for English language proficiency and communicative competence.

This paper proposes a novel methodology for examining these issues as utilized in a research project covering the disciplines of medicine, nursing and physiotherapy. The project aims to identify criteria for effective communication as employed in health professional assessment and reflected in supervisor feedback to trainees.

Methods: The initial phase involves a review of the communication-related assessment criteria in different kinds of workplace based assessment, registration examinations, and specialist training settings. The second phase involves analysis of 12 instances (from each discipline respectively) of communication-related supervisor feedback to trainee health professionals in workplace assessment contexts and in training sessions.

Results: The study's findings show discrepancies between current linguistic criteria used for English proficiency screening, the formal criteria adopted in workplace based assessments and "indigenous criteria" (Jacoby and McNamara 1999) which emerge implicitly from supervisor responses to trainees' performance.

Implications: The paper discusses the implications of these findings for English proficiency assessment for overseas-trained health professionals in particular and for health-related communications skills training more generally.

Larissa Woskob₁; Nora L. Jones; Susan E. Wieggers; Mary Catherine Beach₁; James N. Kirkpatrick

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Medical Practitioner's Perspectives on Guilt as a Motivational Tool

Background/objective: Health professionals report frustration and may be ineffective in engaging patients in behavior change. In this study, we sought to define cardiovascular practitioners' perspectives on using guilt as a motivational tool.

Data and method: We conducted and audio recorded semi-structured interviews with 24 cardiovascular practitioners. Subjects were given a definition of guilt, asked to comment on how often they encountered patients who felt guilty, describe how they responded to those patients, and describe how guilt as a motivational tool might or might not promote lifestyle changes. Interviews were transcribed and coded to identify major themes.

Findings: Most (n=23/24) practitioners reported encountering patients who felt guilty for not taking better care of

themselves. There was no consistent response: 3 practitioners used fear, 6 induced further guilt, 8 provided education, 5 reassured, and 9 used a 'starting over' approach. Practitioners did not agree on whether guilt was an effective motivator; some believed it was ('My thing is 'do you want to see your kids grow up, do you want to walk your daughter down the aisle?' that's guilt, that's healthy guilt and I do use it. And it hits them right in the best spot.'). Others did not ("I do think it's harmful because it lowers the self-esteem."). Several practitioners (n= 8) referenced their own personal experiences or background; only one subject referenced literature on behavior change.

Implications: Nearly all practitioners encountered guilt in patients. There was no standard approach to the use of guilt in motivation, suggesting the need for more training.

**Seraphina Zurbriggen₁; Anke Dunkel (presenting author);
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University of Lugano, Switzerland,₁

From Macro- to Micro-Culture in the Field of Health in Switzerland

The notion of “culture” is very broad and there have been several attempts to define the term during social science history. The literature review we are going to present shows existing research on culture which we classify on a macro and a micro level of culture. Until now the theories about culture have often focused on differences between various nations (Americans and Chinese) or between different ethnic groups (Caucasians and Afro-Americans). From our point of view these studies enter into the definition of “macro level”. But there are more subtle cultural difference than those of heterogeneous societies. Our aim is to show that there are also cultural differences on a micro level in “objectively homogeneous” society such as for example Switzerland. Switzerland with its four official languages and three main language regions therefore is an optimal case to study those differences in an otherwise homogeneous western country.

This perspective on a micro level is particularly interesting in the field of health communication. The authors attempt to argue that these micro diverse cultural differences have an impact on health behavior and thus should be considered when planning campaigns, in particular health campaigns. Since there are only a few empirical findings and hardly no theories on cultural differences in Switzerland in the field of health, this Literature Review provides some necessary background knowledge to elaborate further research about cultural differences and their impact on the effectiveness of campaigns in the field of health communication

POSTER SESSION

Yu Chan Chiu

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Reducing Uncertainty, Enhancing Control and Support: The Role of the Internet in Cancer Patients' Ill Experience

Background/objective: With the rising popularity of using the Internet, it is very common for patients to search online for information related to their diseases. Patient can also post information and discuss issues germane to their disease on the Internet. Thus, it is interesting to investigate how these activities influence patients' ill experience? The aim of this study was, from patients' perspectives, to understand what role the internet play in patients' ill experience?

Data and method: We recruited cancer patients and their family from cancer related websites and associations. Seven focus group interviews were conducted, and a total of forty-six cancer patients/family participated in this study. All interviews were recorded. The inductive qualitative analysis was applied to code and interpret the transcripts.

Findings: The results show that the Internet complemented or even replaced doctor's function of providing information. Patients not only used the Internet to learn medical jargons about their diagnosis and treatment options,

but also to interpret their clinical and laboratory examination data. These activities heavily depended on doctors in the past. The Internet as a major information source decreased patients' uncertainty and gave them more control on their own disease.

In addition, the Internet served an important emotional support function. The virtual social groups, always having someone on-line, could give patients convenient and prompt emotional support when they need it. On the other hand, patients and their family were also willing to share information and experience with others on the Internet. For patients, joining on-line social groups and being acquainted with someone with similar experience gave them a sense of belonging.

Implications: This study found that the Internet helps patients and their families to confront cancer by reducing uncertainty, enhancing control, and support. Future research may explore deeply how patients filter and select information on the Internet and how the use of the Internet affects their communication with doctors.

Wen-ying Sylvia Chou¹; Nancy Burke; Rena Pasick

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Dimensions of Patient-Provider Communication about Colorectal Cancer Screening

Background/Objective: In spite of the identified pivotal role of patient-provider communication on cancer screening utilization, the actual communication process has rarely been systematically examined. This study applies discourse analysis to discussions of colorectal cancer screening (CRCS) in order to describe providers' communication strategies and to identify key themes impacting the effectiveness of CRCS communication.

Methods: Data were collected in an urban integrated healthcare delivery system and community clinics and consisted of 29 videotaped primary care encounters where CRCS was discussed. In-depth linguistic analysis was informed by discourse analytic tools, including a model of discourse coherence (Schiffrin 1987).

Findings: Patient-provider communication about CRCS is multi-dimensional. Providers' communication strategies ranged from exchanging screening information (referential dimension), to accomplishing the goal of

signing the patient up for the test (action dimension), to building interpersonal rapport (social dimension). A key theme that emerged in all three dimensions is the provider's effort at alignment – building, identified through features such as expressions of an empathetic orientation, intertextual repetitions, and voices of the lifeworld (Mishler 1984).

Implications: The analysis shows that a shared understanding of cancer screening is achievable through multiple interactional dimensions. More attention to the dimensions can avert generic one-size-fits-all prescriptions on how to conduct preventive (e.g. CRCS) conversations. Moreover, to enhance cancer screening participation, clinicians may enhance message effectiveness by attending to alignment-building in addition to conveying medical information. Finally, the study demonstrates the utility of a discourse analytic approach in improving our understanding the dynamic communication and decision-making process about cancer prevention.

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*The Encounter's Importance for Making Decisions about Intervention –
Physiotherapists Talking about Patients with Non-Specific Low Back
Pain (NSLBP)*

Institutional encounters between professionals and patients are complex occasions influenced by a variety of confounding factors. Health conditions based on symptoms with multi factorial etiology makes the encounter even more complex. One such common health condition is non-specific low back pain (NSLBP). Conflicting opinions among clinicians and researchers about the underlying nature of LBP, contributes to the complexity. In Sweden primary care physiotherapists meet patients without referral. Therefore it is important to study how physiotherapists understand and manage these patients. The objective was to explore and describe physiotherapists considerations about what that they need to know about patients with NSLBP to make decisions about intervention.

Focus groups with experienced physiotherapists working in primary health care were video-recorded and transcribed. The data were analyzed twofold. First, the content was coded, categorized, and thematized. Coded

symptoms and signs were linked to the International Classification of Functioning, Disability and Health (ICF). Second, the transcriptions and video-films were analyzed considering the physiotherapists accounts. The findings indicate that physiotherapists individualize intervention considering a specific patient's case complexity from a life context perspective, as experienced in the encounter, rather than on a specific diagnosis. Identification of a patient's problems in relation to the ICF contributes to a broader perspective on NSLBP.

Biomedical or psycho-social perspective is not enough to understand a specific patient's problem. A humanistic approach is needed. Further knowledge is needed about the interaction between physiotherapists and specific patients with NSLBP and about how physiotherapists identify patients at risk of developing deteriorating pain problems.

**Devin Larkin; Deborah Milbauer; Adam Hughes; Richard Woy;
Beth Rosenshein; Paul William; Alicia Casali;**

Boston Public Health Commission, USA

*Unintentional Fatal and Non-Fatal Opioid Overdose Prevention:
Coalition-driven strategies in 4 diverse Boston Neighborhoods*

In Massachusetts, abuse of oxycontin and heroin has reached epidemic levels. In 2007, deaths due to opioid-related overdoses (n=637) were over 6 times the number in 1990 (n=94). The crude rate for opioid-related poisoning deaths increased 90.4% between 1999 and 2007 (from 5.2 to 9.9 per 100,000). For every one opioid-related fatal overdose in 2007, there were 47 nonfatal incidents treated at Massachusetts acute care hospitals. To address Unintentional Fatal and Non-Fatal Opioid Overdose, The Massachusetts Department of Public Health, Bureau of Substance Abuse Services, received funding through SAHMSA's Strategic Prevention Framework-State Incentive Grants (SPF SIG). Subsequently, twelve municipality's across Massachusetts, were awarded 3-year 'Mass Call2' grants to create, implement and evaluate a strategic plan. The Boston Public Health

Commission was awarded a 'MassCall2' grant for four Boston-based neighborhood coalitions in Charlestown, South End, South Boston and Roxbury/Jamaica Plain. Each coalition conducted an individualized, in depth community needs assessment utilizing SAHMSA's 'Strategic Prevention Framework', analyzed the results and developed targeted strategies based on the findings. The presentations of the four coalitions will highlight 4 very different strategies designed to meet the unique needs of their diverse neighborhoods while tackling the shared goal of Opioid Overdose prevention. Although the strategies are as diverse as the neighborhoods that developed them, common themes include 'Shared Decision Making', 'Tailoring Health Messages' and 'Communicating Risk and Uncertainty'.

Denise Lautenbach₁; Clara A. Chen; L. Adrienne Cupples; J. Scott Roberts; Robert C. Green

Boston University₁, USA

Developing a Risk Communication Protocol to Disclose “Imminent” Three-Year Risk of Alzheimer’s Disease to Individuals with Mild Cognitive Impairment: The REVEAL Study

Background: A diagnosis of Mild Cognitive Impairment (MCI) and having an APOE $\epsilon 4$ allele are risk factors for Alzheimer’s disease (AD). Some patients with MCI are curious about their risk to develop AD. A protocol was developed to communicate this risk during the fourth funding cycle of the Risk Evaluation and Education for Alzheimer’s Disease (REVEAL) Study, a series of randomized controlled trials examining the impact of disclosing risk for AD.

Methods: Data was obtained from the Memory Impairment Study (Petersen et al. 2005), a clinical trial involving 769 amnesic-MCI patients, which provided three-year risk data stratified by APOE genotype. Cox proportional hazards regression revealed a significant difference in AD risk by age (median split at 73.5 years) and APOE $\epsilon 4$ status (presence vs. absence). Three-year risk curves were created using Kaplan-Meier estimates. A communication protocol

was developed which involves presenting two curves to each participant: 1) three-year risk based on MCI diagnosis, regardless of genotype, stratified by age and 2) three-year risk incorporating APOE $\epsilon 4$ status. Pictographs aid in communicating the numerical three-year risk.

Findings: Among younger individuals, three-year risk was 26.4% based on MCI alone, 40.0% for APOE $\epsilon 4$ positive and 8.5% for APOE $\epsilon 4$ negative participants. Among older individuals, the risk was 41.7% based on MCI alone, 53.1% for APOE $\epsilon 4$ positive and 27.7% for APOE $\epsilon 4$ negative participants.

Implications: Developing a protocol and examining the impact of risk communication is important as APOE and MCI status represent means of identifying higher-risk individuals for future therapeutic opportunities.

Raymond Lee,; Brenda Lovell

University of Manitoba, Canada

Patients' Perceived Barriers to and Facilitators for Achieving Shared Understanding and Decision Making With Physicians – Evidence from Globe and Mail Blogs

Background and Objective: A recent Globe and Mail article reported that difficulties physicians have communicating and establishing a mutually satisfying relationship with their patients, impact the accuracy of diagnosis and treatment. This article was based upon preliminary results from a survey study of communication difficulties experienced by physicians. Responses received were posted to the Globe and Mail blog, a shared online journal where people can post diary entries about their experiences. The objectives of our study were to determine if these blog responses could aid our understanding of the challenges that patients have communicating with their physicians.

Methods: There were 52 responses posted to the blog derived from the respondents' actual experiences with the health care system. Two thematic categories were created and labeled shared understanding and shared

decision making. A general inductive approach to analyze the data was used to identify elements within this thematic framework that promote or inhibit shared understanding and decision making.

Findings: Patients want to be involved in their health care decisions especially managing chronic diseases such as fibromyalgia. They stressed that more emphasis should be placed on health promotion such as diet, education, and body movement. Patients desired mutual respect, less stigma and disapproval of alternative treatments, and providers taking time to listen to their concerns. Health system constraints were identified as posing barriers for both parties.

Implications: The insight gained from the blog was a very revealing and useful form of data that can inform health policy, clinical practice, and further research.

Shuhui Lin

National Cheng Kung University, Taiwan

The Linguistic Device in Medical Encounters: The Use of Continuer vs. Non-Continuer

The full range of patient's concerns in the medical interview affects the doctor's diagnosis and treatment, relationship between doctor and patient, and the outcome of health care. Given its importance this paper explores how to use linguistic devices to elicit or assure information from the patient. The foci are to contrast continuer and other devices and how to combine these linguistic devices to facilitate outcomes. By examining the transcriptions from the data collected in a series of research projects, the results indicate that: (1) continuer elicits new topics from the

patient; (2) the use of 按呐噢, repetition, statement or elaborator inhibits the development of new concerns but it assures old information, help doctors further explore each concern and help the building of good relationship between doctor and patient; (3) to facilitate the full range of patients' concerns, continuers should be used first in the information gathering stage, and then to further explore each concern by the use of other devices, as listed in group 2.

**Caroline Newton; Carolyn Bruce; Jane Dunton; Cinn Teng To;
Hannah Berry**

University College London, UK

It's Not What You Say, It's the Way that You Say It: The Effects of an Unfamiliar Accent on Comprehension in Patients with Aphasia

One of the consequences of the rise in international migration over recent years is that the health services in many countries are now culturally diverse. This has meant that patients are likely to come into contact with a wide variety of unfamiliar accents.

There is now a wide body of research which shows that variation in both native (regional) and non-native accented speech affects speech processing in healthy adults, with deficits greater for non-native-accented speech. However, research also shows that these listeners are able to adapt rapidly to unfamiliar accents.

The research presented here explores the effects of accent on the comprehension of individuals with a compromised language processing system following a stroke or head injury. In three separate experiments, participants with and without aphasia carried out tasks that do not require a

verbal response: a sentence-to-picture matching task, a sentence verification task and a discourse comprehension task. Results indicate that listeners with aphasia made significantly more errors with unfamiliar accented speech than with a familiar accent, and that difficulties with an unfamiliar non-native accent are more marked for these individuals than for participants without aphasia.

The findings so far suggest that unfamiliar accents present particular problems for people with aphasia, which may exacerbate their communication difficulties in some daily life situations. Difficulties in comprehending and adapting to unfamiliar accents may have significant implications for the delivery of healthcare services and the long-term rehabilitation of patients. Healthcare professionals may need to consider these factors when communicating with their patients.

Nurdoğan Rigel; Sebnem Caglar; Ayse Cengiz

Istanbul University, Turkey

*The Ultimate Point In Communication: Violence Towards Doctors In
Emergency Rooms (Er) In Turkey*

Violence towards doctors in emergency rooms is quietly keeping on increasing in Turkey as it is everywhere in the world. In this study, “the violence stories” of the doctors who share their experiences with their colleagues on the internet will be studied through the discourse analysis method. The main purpose of this study is to determine the personal and institutional precautions developed by the doctors who have encountered violence.

During the literature review, it has been observed that the studies on “the violence towards the ER doctors” in the world are rather “case studies” predominantly constituting statistical data (until the middle of the 1990s).

The issue of violence towards doctors in Turkey is just at an “assessment” stage. There have been no “situational

assessment” studies pertaining to metropolitan cities, such as Istanbul, Ankara, Izmir. As the events are reflected in the media (murders towards doctors as the gravest case of violence), what has ever been done about this issue is limited with the indignation declarations of the Medical Associations or the Medical Chambers of the cities where the murders were committed.

In this study, violence towards doctors who are at the highest level of the educated human resources/power along with “institutional precautions” and “individual precautions” will be examined through discourse analysis method. In the respective analysis, the accounts about the violence towards doctors will be explicated on the basis of the “Communicative Action” concept introduced by Jurgen Habermas in interpersonal relations.

Mei-Hui Tsai₁; Feng-Hwa Lu

National Cheng Kung University, Taiwan₁

The Curriculum Design and Effect of a Bottom-Up and Transcription-Based Approach in Teaching Medical Students' Interview Skills

Motivated by the 'learner-centered' process of the bottom-up (alternatively referred to as 'inductive') teaching approach and the rich authenticity provided by transcription of spontaneous doctor-patient interviews, this project aims to integrate both strengths into the course design of medical students' interview skills.

In the spring semester of 2008, the two researchers (Tsai and Lu), a Ph.D. in linguistics and M.D. in family medicine, established a two-credit elective course 'Outpatient Communication and Interview Skills' for medical school students at National Cheng Kung University. The current report focuses on the design of our course plan, which adopts principles of inductive teaching and utilizes transcription as a micro-analytical tool in cultivating students' sensitivity to language use in clinical interviews. Following the four typical steps in implementing an inductive teaching ('observation, formulating patterns, hypothesis, knowledge') and

Miller's (1999) learning pyramid ('knows about, knows how, shows how, and does'), each course plan for a 100-minute class meeting is composed of four parts. The following demonstration uses the theme 'opening the interview' for illustration. (1) 15 minutes: student discuss how doctors create a 'warm and effective' opening stage; (2) 30 minutes: students observe video clips of medical interviews and analyze the transcription with a focus on how doctors open the interview and greet the patient party; (3) 20 minutes; students identify discourse elements and formulate the discourse patterns of what makes an warm and effective opening; (4) 30 minutes: four students work in a group in which student A plays the role of a doctor, B the patient, C patient companion, and D an observer who take notes of how the doctor opens the interaction with the patient party. Student feedback of this course plan design will be collected by qualitative interviews between the teaching assistants and students.

Robyn Woodward-Kron₁; Mary Stevens; Eleanor Flynn

University of Melbourne₁, Australia

The Communication Skills Lexicon: A Linguistic Perspective of the Language of Communication Skills Teaching

Background/objective: Communication skills teaching incorporates a growing lexicon of shared terminology used by medical educators, supervisors and students. Terms such as ‘encouragers’, and ‘mirroring’ are useful descriptors to label strategies and interactive behaviours in the doctor-patient interview; however, there is little in the health communication literature on how these terms are realised through language. This has implications for teaching communication skills as educators can benefit with more awareness about levels of language and linguistic resources (e.g. voice quality, pitch, discourse organisation, speech function) that can contribute to a successful interaction. The aim of this paper is to map the scope of the terminology used in communication skills teaching as well as how these terms are realised through language in doctor-patient interactions.

Data and method: The study setting was International Medical Graduate

communication skills training at two Australian hospitals. Field-notes from fifteen training sessions were analysed to identify the terminology used by the educators to give feedback on communication. Twenty-two video-recorded practice OSCEs from these sessions were then analysed for discourse features corresponding to the identified terminology.

Findings: The findings show that while there was shared terminology to discuss communication skills, this was mostly limited to describing communication strategies. Other levels of language such as discourse organisation received little attention.

Implications: The findings suggest that other aspects of language such as the phonological system play an important role in the success of the interaction. Collaborative studies such as this can inform the building of a comprehensive and accessible lexicon for communication skills teaching.

Rolf Wynn₁; Torbjørg Meum

University Hospital of Northern Norway and University of Tromsø₁, Norway

Staff Satisfaction with the Electronic Handover of Nursing Reports

Background and objective:

Traditionally, nursing reports have been written on paper and the handover (i.e. from one shift to the next) has been oral. An increasing number of institutions have implemented computer systems for nursing records and in some departments, the handover of nursing information is now only done mostly or only electronically. In the present study, we studied staff satisfaction with the use of electronic nursing handover.

Methods: All nursing staff at a psychiatric department at a Norwegian university hospital were mailed a questionnaire about their satisfaction with the electronic nursing handover system in place. Data were analysed with chi-square tests and regression analysis.

Findings: Of the 31 respondents, most were nurses or assistant nurses (68%), and 80% had more than two years of work-experience. 77% were satisfied with the written (i.e. electronic) system for information handover and the same proportion also felt the system was satisfactory in securing that staff were updated on the patients' situation and needs. Staff that expressed a high level of trust in written reports, staff that believed written reports saved time, and staff that deemed other sources of information as less important, were significantly more satisfied with the use of the electronic handover than other staff.

Implications: Most of the nursing staff seemed to be satisfied with the electronic handover of reports. Future studies should address implications of electronic handover for issues such as patients' safety and quality of care.

Besim Yıldırım₁; Dr. Yusuf Yurdigül; Adem Yılmaz

Atatürk University₁, Turkey

Communication Between Patient and Medical Staff: A Research on Erzurum Regional Education and Research Hospital

Medical institutions should operate in a modern way in order to produce active, dynamic, efficient and qualified services. Building communication between patient and medical staff and understanding of each other are important for the continuity of qualified medical services. At the same time, being a part of the treatment process, communication between patient and medical staff should be given due consideration as well. There are too many reasons for communication problems in medical institutions between patient and medical staff, such as patient and his/her relatives may be nervous because of the situation they are in, “informing the patients is a loss of time” opinion may be accepted by most of the doctors and medical staff, doctors may want to treat as much patient as they can because of the payment system based on performance and this attitude leads to time pressure and the hegemonic relation between patient and

medical staff.

In the light of the explanations above, subject of this study consists of communication between patient and medical staff and obstacles that impede the communication. The study intends to specify qualification of communication between patient and medical staff and to propose solutions in order to eliminate the problems occurring between these parties. Medical communication that is covered over the medical institutions, will be analyzed carefully for all stages of patient in a medical institution from polyclinic to clinic. Furthermore, in this study, A questionnaire will be conducted on patients and medical staff of Erzurum Region Education and Research Hospital, the greatest hospital around the East Anatolian Region in Turkey. Also, study will be supported by thorough interviews with nurses and care assistants

WORKS IN PROGRESS

- *Each presenter will present their topic for 15 minutes*
- *A table moderator will coordinate and facilitate table discussions*
- *To facilitate focused interdisciplinary discussion roundtable abstracts have been grouped according to the following topics:*

1. Eliciting and Understanding Perspectives of Children & Adolescents

Bastos: Violence and Health – The Experience of Young Dwellers of an Urban Conflict Zone

Bertell: Psychoanalysis with Infants – Is it Possible?

Pickering: Interviewing Children with Cerebral Palsy - How do we Represent their Voice?

2. Teaching Communication to Health Care Professionals: Identity Construction

Koenig: Identity Construction in Reports by Medical Students

Pinto Cadilhe de Assis Jácome: Discourse Technologization and Medical Education: The Use of Role-Play in the Construction of Competencies and Professional Identity

Ribeiro: An Analysis of Communicative Styles of Brazilian Healthcare Providers in US Healthcare Settings

3. Telemedicine: Ethics

Kreucher: Ethical Issues in Telemedicine: The Emergency Case

Laryionava: Telecardiology - New Quality of Health Care?: A Patient-Centered Approach

Keiser: In-Home Healthcare in Taiwan and Beyond

4. Communication training for future health care practitioners: Outcomes that matter, how and what to measure?

Barone: Doctor Elicitations and Patient Narratives: Seeking Coherence

Burke: Can You Hear Me? Training Health Care Students for Effective Interprofessional Communication

Rao: Expanding the Four Habits Model to Include the Patient's Perspective: Results of a 4 Round Delphi Study

Stokes: Governance and ethics in the education of health professionals

5. Mental Health: Communication

Baldwin: 'Introducing Brief Ordinary and Effective (BOE) Healthcare Communication to an NHS Mental Healthcare Trust using Clinical Innovations Networks.'

1. Eliciting and Understanding Perspectives of Children & Adolescents

Liliana Bastos

Pontifical Catholic University, Rio de Janeiro, Brazil

Violence and Health – The Experience of Young Dwellers of an Urban Conflict Zone

Although urban violence is not a health problem per se, it is a highly relevant issue to health studies and public health policies, since it generates injuries, traumas and death, having lately reached higher rates than, for example, infectious diseases (Minayo, 2006). In the Work in Progress Round-Table, I would like to discuss a new research project which addresses the experience of violence and health related issues, from the perspective of children and adolescents who live in a conflict zone, under the influence and control of the local drug traffic in Rio de Janeiro. The youngsters whose talk will be studied are presently attending different kinds of workshops (sports, dance, music, etc.) offered by a project coordinated by healthcare professionals, and carried out by members of the local community. I am proposing to analyze the narratives produced by these youngsters, in focus group meetings and in individual research interviews.

It is my belief that a micro-interactional approach to narrative analysis is a powerful tool to understand what happens in this environment, as well as to how talk between children and healthcare professionals is organized. Given its focus on discourse, this type of analysis is intended to benefit not only the practice of healthcare professionals in such contexts (identifying communication problems, for example), but also the discussion on issues related to the experience of violence and the construction of subjectivity (Das, 2000), the personal and the collective experiences of suffering (Kleinman, 2000), and the construction of strategies for coping with violence in daily life (Caldeira, 2000).

Works In Progress

Ida Bertell

Department of Education, Stockholm University, Sweden

Psychoanalysis with Infants – Is it Possible?

The purpose of the study is to investigate client –professional encounters in psychoanalytic treatment of infants, the so-called Infant Psychoanalysis (IP), from a phenomenological social science perspective. IP is a clinical treatment where a psychoanalyst meets an infant together with his/her parent(s), however the psychoanalysis and the interventions (for example interpretations and dialogue) are directed exclusively towards the infant and not towards the parents, as is the more traditional way in for instance infant-parent therapy. The parents have come to treatment with their child because the infant for some reason has developed signs of distress (for instance eating or sleeping disorders).

I will in my talk describe the dialogue between the psychoanalyst and the infant on the basis of in-depth interviews with nine psychoanalysts, and on video-taped material from four IP-sessions. The task of the psychoanalyst is to give voice to the experience of the infant. How can we understand this act of communication, where one part does not have the capacity to communicate through spoken language? My analysis contains a critical examination of the analyst's explicit purpose of doing psychoanalysis with infants. There seems to be a discrepancy between what the psychoanalysts say that they do and what they actually do. Goals for roundtable discussion could be: Is psychoanalysis with infants possible, and, if so, how can it be understood? I would also like to discuss ethical aspects of this treatment.

Works In Progress

Dawn Pickering

Cardiff University, UK

Interviewing Children with Cerebral Palsy - How do we Represent their Voice?

This presentation will present extracts from a transcript of interview data collected from a research project, exploring the views of children with Cerebral Palsy who participated in adapted dynamic cycling. This case study of a 10 year old child, with limited verbal communication, demonstrates the need for the parents/ guardians to be present to interpret the spoken language. This practice of interviewing children with a responsible adult present means it is harder to find out the child's view. Ethical concerns are expressed in terms of interviewing children who have a disability, under the age for consent (16 years), without an adult present. The challenge of enabling children with cerebral palsy to have a voice to express their views will be discussed. Methods other than verbal interview will be explored.

Reflections will be expressed of how the researcher changed the nature of the questions from open to more closed questions in an attempt to enable the child to respond with one word answers. The ability of the researcher to reflect in action to adapt these communication skills will be discussed.

Goals for roundtable discussion: To explore what other methods people have used to obtain the views of children with communication difficulties. To discuss the ethical concerns of doing research with children with limited verbal communication.

Works In Progress

2. Teaching Communication to Health Care Professionals: Identity Construction

Regula Koenig; Miriam Locher

English Seminar, University of Basel, Basel, Switzerland

Identity Construction in Reports by Medical Students

My PhD thesis is a part of the SNF-project "Life (Beyond) Writing: Illness Narratives". The aim of this project is to explore the socially and culturally constructed meanings of illness narratives, including their role and function in the fields of literature, linguistics and medicine.

For the linguistic part of this project we will collect a corpus of written reports by medical students from Basel and Nottingham (U.K.). After an internship with a GP, students have to write a short report on a conversation with a patient, reflecting on their usage of communicative strategies and on some of the problems they encountered. The purpose of this report is to give students an opportunity to think about what they had learned previously in their communication skills training and what difficulties the application of that knowledge entails.

My thesis will focus on how medical students construct identities within these written reports and how they reflect on identity constructions in their reports (if at all). As my thesis is still at an early stage, there are no preliminary results yet to be presented.

One of the aims of this project is to let the results of our study flow back into the teaching of communication skills, in order to improve current and future communicative training of medical students. The goals for this roundtable presentation are to get feedback from fellow researchers and to foster interdisciplinarity between the fields of linguistics, literature and medicine.

Works In Progress

Alexandre José Pinto Cadilhe de Assis Jácome; José Carlos Gonçalves

Universidade Federal Fluminense - UFF / Centro Universitário Serra dos Órgãos, UNIFESO, Brazil

Discourse Technologization and Medical Education: The Use of Role-Play in the Construction of Competencies and Professional Identity

This study aims at understanding how communicative competence and professional identity are constructed by medical students through role-play. It is situated in the scope of the contemporary trend of the technologization of discourse (Fairclough, 1990), in which discourse is used as a resource or tool to achieve certain institutional objectives. In the health context, this perspective can be understood as a way towards a humanized professional identity, in consonance with Brazilian public health policies. In this study, two videotaped simulations of consultations by medical students are analyzed, as well as an oral discussion of the consultations run by an instructor and a group of medicine freshmen students in a Skills Lab activity. The data were transcribed and analyzed within the methodological constraints of the microethnography of speech and conversation analysis. Results point to different identity performances and discourses which converge towards the intended objective, that of doctors' humanization.

A caveat is due: patientless simulations are different from real life interactions and do not guarantee the practice of humanized care in real life work situations. This theme relates to the context of professional medical education, subsuming ethics as a necessary condition for professional humanization. The presentation aims at discussing mechanisms and issues in the analysis of data, as well as implications for research and development of professional education and training.

**Branca Ribeiro; Marcia Guimaraes; Clemence Jouet Pastre;
Solange Lira**

Lesley University, USA

*An Analysis of Communicative Styles of Brazilian Healthcare Providers
in US Healthcare Settings*

Brazilians constitute a relatively new group of immigrants to the US, specifically to Massachusetts and to the Boston area. Large numbers (around 150.000) arrived in the last two decades. American health care providers have turned their attention to explore the health needs of Brazilians, specifically what cultural references (expectations and assumptions) frame their interaction with this population, so as to better understand differences that emerge in healthcare settings (Roberts, 2007; Cohen et al, 2007; Messias, 2004).

In this discussion, we propose a shift. We focus on the perspective of Brazilian health care providers (specifically physicians and social workers) who have immigrated as professionals to the US. We explore how the Brazilian healthcare provider adapts to the US healthcare system through retraining and the acquisition of new strategies for communication and interaction. Preliminary data analysis points to contrastive educational experiences (in Brazil and in the US), to the acquisition of an “American medical discourse” (where styles of communication differ) and the performance of new identities (the bilingual/bicultural Brazilian

American HCP). Issues related to specific discursive practices (such as disclosing bad news, asking direct questions, responding to family members), are discussed.

Our data derives from taped interviews with Brazilian health care providers, practicing in the Boston area for at least the last two years. All HCPs have been educated in Brazil and in the US. The group encompasses a range of professionals (social workers, physicians, and psychologists).

Goals: To understand how foreign born health professionals develop communicative and cultural competence within the American health system; what support structures are available for these professionals; how these foreign born healthcare professionals integrate prior ways of speaking (Hymes, 1974) in U.S. clinical settings so as to interact successfully with American and foreign born patients. The implications of this work relate to a better understanding of intercultural communication in healthcare settings, not only for Portuguese speakers and Brazilians, but also for Latinos and other immigrant communities.

3. Telemedicine: Ethics

**Sabrina Kreucher; Katsiaryna Laryionava (presenting author);
Jens Lohmeier**

**Institute for History, Theory and Ethics in Medicine at RWTH
Aachen University, Germany**

Ethical Issues in Telemedicine: The Emergency Case

Within the context of the project "Gender-related Acceptance, Usability and Ethics in New (Medical) Technologies" we analyse the acceptance of telemedicine taking into account different perspectives (emergency doctor, ambulance officer, patient etc.) in order to spot out particular problems of each participant. Thereby we identify between two initial situations: standard and emergency. This is done for two main reasons: First the change of circumstances considerably influences the characteristics of acceptance; second the case of emergency is barely explored. For our presentation "Ethical Issues in Telemedicine: The Emergency Case", we revert to a concrete example: the pilot scheme "Med-on-Aix". The project is on a special ambulance vehicle which allows an additional Tele-Emergency-

Doctor to advice and assist the emergency doctor on location. The Tele-Doctor is situated in a control center and receives every medical data of the patient directly from the scene of emergency via wireless data transfer (amongst other things a tablet-PC, headsets, ECG and video camera). By these means, he can access databases for example, which are impossible for the emergency doctor on location to consult. The discussion should focus on the ethical problems which could occur by using the new system: Which issues emerges for the specific actors? Where is need for action to avoid the rejection of telemedicine on the part of the different group of persons? Which methods could be used best to examine potential problem areas?

Works In Progress

Katsiaryna Laryionava; Sabrina Kreucher

**Institute for History, Theory and Ethics of Medicine at RWTH
Aachen University, Germany**

*Telecardiology - New Quality of Health Care?: A Patient-Centered
Approach*

Telemedicine has begun to play an increasing role in the monitoring of body-related technologies such as the implantable cardioverter-defibrillator (ICD). Its overall general worth as a viable option in the medical profession, though, has come into a shadowy gray area causing somewhat controversy. On one hand, telemedicine support may increase patient safety, improve quality of life and reduce the risk of sudden cardiac death due to ventricular fibrillation. On the other hand, it raises major ethical and social questions, as well as possible psychological issues for the patient: one current topic of discussion is the new possibilities of health telematics in implantable devices, which may require a new way of dealing with altered circumstances. The aim of this empirical study, which is a part of the interdisciplinary project at RWTH Aachen, "Gender-related Acceptance, Usability and Ethics in New (Medical

Technologies", is to identify problematic fields connected with telemedicine application in ICD patients. Methods: We have conducted semi-structured interviews with patients, both male and female, who have been implanted with an ICD with remote monitoring at the University Hospital in Aachen, Germany. They have been asked to participate in the investigation of questions such as: What impact, either positive or negative, does a telemedicine application have on the quality of life? Does it have any impact on one's personal identity, body-perception and experiences of illness-related health issues? What influence does the changing doctor-patient relationship through telemedicine have on coping with diseases and health perception? What are the patients' expectations regarding this novel technology? Are there any gender differences relating to these questions?

Works In Progress

Gerd Keiser

National Taiwan University of Science and Technology, Taiwan

In-Home Healthcare in Taiwan and Beyond

Caring for sick, disabled, and elderly people in a home environment is a growing trend in many countries. This is especially true in Asian countries such as Taiwan. Our research is examining existing and emerging healthcare monitoring devices and methods, which can easily be used in a home environment to offer the affected people a better quality of care and quality of life. However, the cultural acceptance of some aspects of healthcare monitoring in Taiwan differs from the acceptance in the USA. Whereas the solutions to remote healthcare monitoring can be achieved in a number of ways, the ethnic culture in certain communities may hinder widespread acceptance of proposed devices or methods. Researchers and healthcare providers must be aware of strong beliefs by various segments of the public in

traditional oriental healthcare methods and a cautionary or sometimes even a distrustful view of western-based solutions.

Our goal for the roundtable discussion is how to develop multimedia-based materials that address how to cope with a specific health problem. This material should be easily understandable and demographically oriented, that is, the content should be aimed at people with certain types of cultural backgrounds and ideally should be of interest to all age groups. In terms of usefulness to participants, the ideas being investigated can be used not only in Taiwan but in most other countries worldwide as well. Although each application will require some cultural and language modifications, the fundamentals remain constant.

*4. Communication training for future health care practitioners:
Outcomes that matter, how and what to measure?*

Susan Barone

Vanderbilt University, USA

Doctor Elicitations and Patient Narratives: Seeking Coherence

This topic addresses the relationship between provider elicitation and patient narratives. Coming from a sociolinguistic perspective using discourse analysis, I analyze how interactional narratives and the more recent clinical approach of Narrative Medicine (NM) (Charon, 2006) intersect. NM contends that given “space” in which to speak, the patient will tell the story her health condition. This research explores the impact of such an approach on clinicians and patients. Preliminary findings seem to indicate that when patients are given “space” in which to speak, particularly when patients are dealing with chronic illness, narratives tend to be less coherent. Although other research has found that patient narratives are less coherent than narratives found in everyday speech, chronicity has not been fully explored. Also, the NM approach poses that clinicians develop narrative competencies in which to understand patient narratives. If this is the case,

how does one develop competencies of determining what is salient to patients’ conditions when narratives are less coherent?

From my data analysis, I have found that each participant is seeking narrative coherence. Providers seem to use questions which not only elicit the type of information they deem necessary but also a patient narrative which assists in making sense of the patients presenting concern.

Reconsideration for how we understand and analyze narrative using traditional analytic approaches is emphasized as current tools have only begun to recognize the complexity of patient narratives, which may be less coherent.

Discussion is sought involving patient narrative, clinician elicitation, methodology, and implications for clinicians-in-training.

Works In Progress

Janice Burke; Lauren Collins

Thomas Jefferson University, USA

Can You Hear Me? Training Health Care Students for Effective Interprofessional Communication

New models of client and family-centered care call for health care delivery changes incorporating principles and practices of interprofessional team care. Effective delivery of such care relies on strong verbal and non-verbal communication skills of all team members to improve patient satisfaction, patient commitment to recommendations, and health outcomes (1-4). Nevertheless, communication skills training in medical schools and schools of health professionals is inconsistent, underdeveloped, and frequently occurs in silos.

This “work in progress” builds on a recently completed pilot study evaluating verbal and non-verbal communication skills in an OSCE (objective structured clinical examination) with 19 medical students, residents, fellows and standardized patients (trained actors). Medical interviews were videotaped and evaluated on a 14 item verbal, 8 item non-verbal communication checklist (designed for project). Findings revealed significant effects of non-verbal communication (postural change, facial expression, affirmative gestures, etc) on

perception of interview quality reported by standardized patients.

The authors are interested in how this study informs new work measuring verbal and nonverbal communication in an interprofessional trainee group. Following a university wide initiative, the purpose of the training is to improve delivery of patient/family centered interprofessional care in medical, nursing, occupational and physical therapy, and pharmacy students.

Goals: Determine a common set of communication skills to bridge communication gaps between professions/ patients and across the team. Will this contribute to a unified approach to patient care? improved quality of care? Improved patient/family perception of quality of care?

Identify three patient scenarios to best exemplify the need for interprofessional team communication skills (ex. breaking bad news; caring for an unstable patient; transitions in care).

Develop an OSCE-oriented checklist to evaluate verbal and nonverbal skills needed in each scenario.

Works In Progress

Jaya Rao; Lynda Anderson; Terry Stein; Richard Frankel

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Expanding the Four Habits Model to Include the Patient's Perspective: Results of a 4 Round Delphi Study

Summary of content: The Four Habits Model is a teaching and research framework for physician communication based on evidence linking specific communication behaviors with outcomes of care. Using the Model as a starting point, we sought to identify an initial set of patient verbal communication behaviors considered important to outpatient encounters. To accomplish this goal, we conducted a 4-round Delphi study with 17 international experts in communication research, medical education, and health care delivery. In round one, 14 verbal patient communication behaviors proposed by the authors were evaluated and new behaviors were solicited. In subsequent rounds, behaviors were rated on their fit and appropriateness to the habit; behaviors reaching consensus (>70% agreement) were moved into the final model or dropped. After 3 rounds of ratings, 22 patient behaviors reached consensus. The behaviors were

distributed across the habits, with 4 in Habit 1, 8 in Habit 2; 2 in Habit 3, and 8 in Habit 4 and included behaviors such as asking questions, expressing preferences, and summarizing information.

How topic relates to communication, medicine, and ethics:
Identifying a core set of patient communication behaviors is critical to adding the patient's "voice" to the Four Habits Model. This helps create a Model that recognizes and integrates patient and physician communication behaviors that affect the course and direction of the medical encounter.

Goals for discussion:
1) Advice on approaches for validating the initial set of patient behaviors derived from our expert consensus process
2) Advice on potential next steps and funding sources

Works In Progress

Adrian Stokes

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Governance and ethics in the education of health professionals

The rationale for the emphasis on ‘research governance’ as the dominant frame of reference in educational processes relating to ethical issues is unstated and arguably reflects the structures of power and influence that operate in accrediting institutions, in particular research-intensive universities.

While the benefits of thorough review are clear, there are two unwelcome consequences of handling ethical issues arising from primarily educational activities within research governance arrangements. The first is that research ethics committees were not conceived to scrutinise educational projects and are often not well integrated with the other academic, professional and administrative aspects of the educational programme. ‘Expedited’ procedures are not necessarily a solution, since it is the orientation and integration of the review, as well as the

speed, that are problematic. The second problem is that the many other ethical issues that arise through the educational process can be obscured and although they do receive attention it is frequently not through the discourse of ‘ethics’ and not framed in terms of ‘governance’. A coherent, comprehensive framework for consideration of ethical issues arising from educational processes seems to be lacking.

Goals for roundtable presentation:

To explore participants’ experiences of managing the interrelationships between clinical ethics, research ethics and educational ethics.

To consider how a framework for educational ethics could be constructed and operate alongside research governance and clinical governance

5. *Mental Health: Communication*

Laurence Baldwin; Paul Crawford

**University of Nottingham / Derbyshire Mental Health Services
Trust, UK**

*'Introducing Brief Ordinary and Effective (BOE) Healthcare
Communication to an NHS Mental Healthcare Trust using Clinical
Innovations Networks.'*

This discussion is of a recently launched project to introduce the concept of Brief Ordinary and Effective (BOE) healthcare communication to a busy working NHS mental healthcare trust. The concept of BOE has been published and forms part of the Chief Nursing Officer's Review of Mental Health Nursing (DoH 2006). In a busy mental health trust which is focussed on managerial key performance indicators, however, it is important to be able to introduce clinically focussed ideas (such as BOE) in the face of a managerial structure which may be putting emphasis on more measurable (and target-driven) factors. This discussion will focus on the concept of Clinical Innovation Networks (CINS) as a way of using practitioner enthusiasm for a clinically focussed approach as a way of organically

growing the concepts within a busy clinical environment. By building these concepts into existing structures (Quality Strategy and Research Strategy) the CINS have begun a process of engaging practitioner energy to allow creativity in developing new approaches to effective communication. It will focus on progress so far, the ideas generated within the healthcare setting and look for further ideas from the roundtable discussion for further progressing the introduction of BOE in a variety of mental healthcare settings. Although based in a UK NHS setting it is hoped that the discussion will be applicable to an international audience by focussing on the engagement of practitioner enthusiasm for dissemination of new ideas within clinical settings.

Works in Progress

Jonathan Delman; Jack Clark

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"Achieving, Experiencing and Sustaining Active Participation in Making Psychiatric Medication Decisions: The Perspective of People with Mental Illnesses"

Studies show that while many people with serious mental illness (SMI) want to be active participants in making medication decisions with their psychiatrists, they often are not. The goal of our study is to learn about and document how people with SMI achieve, experience and sustain active participation in treatment decision making. Our conceptual model and interview guide are based on Finfgeld's empowerment model, in which a client's level of activation is seen as a fluid process based on its antecedents, barriers, and outcomes. We are currently conducting qualitative interviews with 25 adults who are active participants medication decision-making, and will conduct grounded theory analysis to fine-tune Finfgeld's model and to produce testable hypotheses for further study. This presentation will include

- the study's conceptual model
- the study's methodological approach
- a review of the progress of data collection
- a review of preliminary content of data analysis

This study topic relates directly to how clients and psychiatrists communicate to make medication decisions. These issues are particularly acute in mental health given the unnecessary level of coercion often used in gaining patient "compliance"; that is many psychiatrists are not familiar with the appropriate ethical standards for ignoring patient preferences, or simply believe that it is their moral duty to ignore their ethical duties.

The goals for this roundtable are to share both methodological and conceptual issues with attendees. This will be of particular interest for other people doing qualitative work in health care communications and others researching mental health services

