CONTENTS

Dear Colleagues,

We are delighted to welcome you to the 11th Interdisciplinary COMET conference 2013, and to the University of Melbourne, Australia. We would also like to extend a warm welcome to our plenary speakers.

COMET 2013 at the University of Melbourne introduces a student bursary for the most outstanding student abstract, a professional development workshop, a Special Interest Group meeting for health professional educators, and a session on publishing healthcare communication and ethics research.

We hope you enjoy the programme and your stay in Melbourne

Robyn Woodward-Kron, PhD
Convenor
COMET 2013 Melbourne

The COMET Conference Committee
[1]Associate Professor Robyn Woodward-Kron,
[1]Dr Eleanor Flynn,
[2]Ms Cathleen Benevento,
[1-2]Mr John Pill,
[1-2]Dr Catriona Fraser,
[3]Professor Elizabeth Manias,
[4-5]Associate Professor Clare Delany
[6]Professor Marilys Guillemin
[2]Professor Tim McNamara

[1]Medical Education Unit, Melbourne Medical School, University of Melbourne
[2]Language Testing Research Centre, School of Languages and Linguistics, University of Melbourne
[3]Nursing, School of Health Sciences, University of Melbourne
[4]Physiotherapy, School of Health Sciences, University of Melbourne
[5]Royal Children's Hospital, Children's Bioethics Centre
Centre for Health & Society, Melbourne School of Population & Global Health, University of Melbourne

International Committee:
Srikant Sarangi, Cardiff University
Peter J. Schulz, Università della Svizzera italiana
Gøril Thomassen, Norwegian University of Science & Technology

Finding Your Way Around
The conference will take place on the ground floor and on the second floor of the Law Building, Building 106 (See page 10 of this booklet for an area map). The reception will be held in the Ian Potter Museum of Art (Building 136), University of Melbourne, on Swanston St. Please meet at the registration desk at 5.20pm to meet guides to walk to Swanston St (10 min walk). The conference dinner and book launch will be held in University House, Building 112. A map insert showing the University building numbers is in your conference bag.

Technical Support
All presentation rooms are equipped with a computer, projector and screen. If you sent your presentation file ahead of time, we have 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. If you have not sent your presentation prior to the conference, please load your presentation into the folder for your session on the desktop in the room in which you are presenting. A dedicated IT support person will be available throughout the conference. Instructions for using the computers are available in each room.

Access to Uniwireless
A Uniwireless account had been created for COMET delegates for the duration of the conference
Guest User Name   COMET2013
Password   IsPjr77x
A laptop computer will be available at the registration desk for quick Internet access throughout the conference.

Welcome to Country
Aunty Dianne Kerr, Wurundjeri Elder, will give the Welcome to Country for COMET conference delegates.

A Welcome to Country is a ceremony performed by Aboriginal or Torres Strait Islander people to welcome visitors to their traditional land.

Aunty Di is passionate about the wellbeing of Koori people, she is a foster mum of 26 years, she has worked for Stolen Generations for over 10 years and is currently working in the area of wellbeing and research.
Aunty Di is a Director of Native Title Services Victoria, and a Chairperson of the Royal Women's Hospital Indigenous Advisory Committee.

Billibellary's Walk: **Indigenous walking tour of University of Melbourne campus**
At the close of the conference, Mr Charles Solomon from the University of Melbourne will conduct an indigenous walking tour. The tour is a cultural interpretation of the landscape and will provide an experience of connection to country which Wurundjeri people continue to have, both physically and spiritually. Please meet at the registration desk at 1.30 on Saturday.

More about Billibellary's walk
http://www.murrupbarak.unimelb.edu.au/content/pages/billibellarys-walk

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 2013. 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).

Useful Telephone Numbers

Taxi: 13 Cabs – 132 227; Silvertop Taxis – 131 008

Police/Fire/Ambulance: 000

Thursday July 11th

Time	Activity	Location
8:15-9:25	Registration	Foyer, Law Building
9:30-9:45	Conference opening	Auditorium/G08
9:45-10:00	Welcome to country	Auditorium/G08
10:00-11:00	Plenary I	Auditorium/G08
11:00-11:25	Morning break	Ground floor, Law Building
11:30- 12:55	Parallel session 1	Ground floor, Level 2
1:00-1:55	Lunch	Ground floor, Law Building
2:00-3:55	Parallel session 2	Ground floor, Level 2
4:00-4:30	Afternoon break	Ground floor, Law Building
4:30-5:15	Workshop	Auditorium/G08
5:30-7:00	Welcome reception	Ian Potter Museum of Art

Friday July 12th

Time	Activity	Location
8:30-9:00	Registration	Foyer, Law Building
9:00-10:25	Parallel session 3	Ground floor, Level 2
10:30-10:55	Morning break	Ground floor, Law Building
10:30-11:25	Poster session	Ground floor, Law Building
11:30-12:55	Parallel session 4	Ground floor, Level 2
1:00-1:55	Lunch	Ground floor, Law Building
1:15-1:55	Health Professional Educator SIG Meeting	G14
2:00-3:25	Parallel session 5	Ground floor, Level 2
3:30-4:00	Afternoon break	Ground floor, Law Building
4:00-5:00	Plenary II	Auditorium/G08
5:00-6:30	Free time	
6:30-7:30	Book launch	Upper East Dining Room, University House
7:30-10:30	Dinner	Matthaei Room, University House

Saturday July 13th

Time	Activity	Location
8:30-9:00	Registration	Foyer, Law Building
9:00-10:55	Parallel session 6	Ground floor, Level 2
11:00-11:25	Morning break	Ground floor, Law Building
11:30-12:30	Plenary III	Auditorium/G08
12:30-1:00	Closing remarks	Auditorium/G08
1:00-1:30	Lunch	Ground floor, Law Building
1:30-3.00	Indigenous walking tour	Meet at registration desk

CONFERENCE AREA MAP

DETAILED SCHEDULE

Thursday 11 July 2013

8.15-9.25	**Registration** Foyer, Law Building http://maps.unimelb.edu.au/parkville/building/106				
9.30-9.45	Auditorium/G08				
9.45-10.00	**Conference Opening:** *Professor Margaret Sheil, Provost, University of Melbourne* **Welcome to Country:** *Auntie Dianne Kerr, Wurundjeri Elder*				
10.00-11.00	Plenary Session I: *Professor Fernando Martin Sanchez, University of Melbourne* *Participatory health: the role of informatics and implications for the patient-physician encounter* Chair: Robyn Woodward-Kron				
11.-11.25	Morning Break, Ground Floor, Law Building				
Room	G08/Auditorium	G27	G29	223	224
Parallel Session 1	**1A Distributed Expertise** Chair *John Pill*	**1B Quality of Life / Quality of Care** Chair *Marilys Guillemin*	**1C Health Literacy** Chair *Catriona Fraser*	**1D Consent** Chair *Clare Delany*	**1E Interprofessional & Multidisciplinary** Chair *Eleanor Flynn*
11.30-11.55	1A.1 *Rodney Jones* Knowledge construction and expertise in online discussions of genetics	1B.1 *Jill Yamasaki* The communicative role of companion pets in patient-centered critical care	1C.1 *Rosemary Clerehan, Catherine Elder, Margaret Staples, Richard Osborne & Rachelle Buchbinder* Medical terms in patients' words: implications for clinical communication	1D.1 *Rosalind McDougall & Lynn Gillam* Clinicians' "decisions" versus parents' "wishes": ethical implications in conflict situations	1E.1 *Heather Lane, Jennifer Philip & Sue-Anne McLachlan* Discussion of Age and Age Related Issues in Cancer Multidisciplinary Meetings
12.00-12.25	1A.2 *Natalya Godbold & Marie Manidis* Collaborating healthcare knowledge: knowing online and in emergency departments	1B.2 *Johan Barstad, Siv R. Osdal, Solrun Osdal & Roar Stokken* Left hanging in mid-air. Patients experiencing complex return journeys from hospital	1C.2 *Valerie Youssef & Stella Williams* When the foot reaches the knee: health literacy and the burden of communication re-examined	1D.2 *John Cartmill & Maria Dahm* "When the wheels fall off." – Making use of overlaps in communicative strategies between obtaining informed consent and breaking bad news	1E.2 *Elizabeth Manias, Sharon Kinney, Noel Cranswick & Allison Williams* Effects of interprofessional communication problems on medication errors in hospitalised children

12.30-12.55	1A.3 *Franziska Thurnherr* "Together, we will look for the path ahead and the life you can make whole again." The relationship between therapist and client in email counseling as the driving force for change	1B.3 *Katja Beitat* The role of trust between medical practitioners and patients after medical incidents	1C.3 *Peter Schulz & Silvia Riva* Judgment and Decision Making (JDM) in the frame of health literacy: The *fil rouge* of research	1D.3 *Stephen Honeybul*, K. M. Ho & S. O'Hanlon Communicating risk and uncertainty: obtaining consent for life saving but non restorative decompressive surgery	1E.3 *Rintaro Imafuku, Ryuta Kataoka, Mitsuori Mayahara, Hisayoshi Suzuki, Yasuyuki Suzuki & Chihiro Kawakami* Students' participation and introspection in interdisciplinary PBL tutorial: Implications for interprofessional education
1.00-1.55	Lunch, Ground Floor, Law Building				
Room	G08/Auditorium	G27	G29	223	224
Parallel Session 2	**2A Colloquium: Effective communication in clinical interactions:** Moderator **Suzanne Eggins**	**2B Communicating Risk & Uncertainty / Health informatics** Chair **Sascha Rixon**	**2C Mediated Communication, Decision Making** Chair **Sandra Braaf**	**2D Work in Progress** Chair **Elizabeth Manias**	**2E Risk and Uncertainty / Ethics** Chair **Ros McDougall**
2.00-2.25	2A.1 *Suzanne Eggins & Diana Slade* Interaction: recognising the missing dimension in accounts of clinical handover	2B.1 *Michael Arribas-Ayllon* Decoding a syndrome: interpreting direct-to-consumer genetic tests in online forums	2C.1 *Anna Gustafsson* Empowering strategies in children's diabetes consultations with doctors and immigrant parents	2D.1 *Harriet Etheredge, Claire Penn & Jennifer Watermeyer* Interprofessional communication and organ transplantation in South Africa	2E.1 *Tina-Marié Wessels & Claire Penn* "So the doctors saw you …" How context shapes genetic counselling interactions in Johannesburg, South Africa
2.30-2.55	2A.2 *Edward Stewart-Wynne, Michael McComish, Fiona Geddes, Dorothy Jones & Phillip Della* iSoBar as a teaching framework and considerative checklist for clinical rounds in an inter-professional student training ward	2B.2 *Marie-Thérèse Rudolf von Rohr* "Everyone's quit journey is different": comparing persuasion on two smoking cessation websites	2C.2 *Simon Musgrave, Marisa Cordella, Louisa Willoughby & Julie Bradshaw* Triadic medical interaction with a bilingual doctor	2D.2 *Michael McKeon* Physical activity of men with intellectual disability	2E.2 *Jean Paul, S. Metcalfe, L. Stirling & J. Hodgson* Communication about diagnostic uncertainty in paediatric genetics: "It's challenging and a bit frustrating"

3.00-3.25	2A.3 *Marian Lee & Jeanette McGregor* The educational benefits of the medical ward round for Junior Medical Officers	2B.3 *Yen-Hsuan Sung, Mei-hui Tsai & Po-Kai Chang* The "worried well" and "upper-mid" HIV/AIDS Test Takers: Discourse Patterns as Possible Clues to Personal Characteristics of Users on a Taiwanese Online HIV/AIDS Forum	2C.3 *Helen Tebble* Interpreter mediated healthcare delivery: client-professional encounters	2D.3 *Margo Turnbull* An archaeology of the primary health care patient: an examination of public and private identity	2E.3 *Jaklin Eliott, Ian Olver & Annette Braunack-Mayer* When one of us gets cancer: the enduring impact on the family
3.30-3.55	2A.4 *John Walsh & Jon Jureidini* Clinical communication in the context of mental health	2B.4 *Silvia Riva, Alessandro Antonietti & Peter Schulz* Simple and Honest signals in Patient-Doctor communication		2D.4 *Amy Hiller* Considering the role of communication models in client-professional encounters: a physiotherapy perspective	2E.4 *Olga Zayts & Srikant Sarangi* 'Treat him as a normal baby': Paediatrician's framing of parental responsibility as advice in the management of a genetic condition
4.00-4.30	Afternoon Break, Ground Floor, Law Building				
4.30-5.15	G08/Auditorium **Workshop**: Addressing ethical issues in the practice of communication research ***Marilys Guillemin & Lynn Gillam, University of Melbourne***				
5.30-7.00	**Welcome Reception** Ian Potter Museum of Art, University of Melbourne, 800 Swanston St *(10 mins walk from conference venue)* http://www.art-museum.unimelb.edu.au/				

Friday 12 July 2013

8.30-9.00	Registration Foyer, Law Building				
Room	G08/Auditorium	G27	G29	Room 223	Room 224
Parallel Session 3	**3A Public Understandings of Health & Illness** Chair *Peter Schulz*	**3B Inter/Intraprofessional Communication** Chair *Rosemary Clerehan*	**3C Quality of Life / Quality of Care** Chair *Heather Lane*	**3D Communication Skills** Chair *Sandra Braaf*	**3E Medical Education / Ethics** Chair *Sally Warmington*
9.00-9.25	3A.1 *Anneliese Synnot, Sophie Hill, Graziella Filippini, Michael Summers, Sue Shapland & Richard Osborne* Knowledge translation for consumers: development of an evidence-based health information website	3B.1 *Bettina Sletten Paasch* Health care practitioners' use of wireless phones in hospital settings can affect interprofessional communication and patient encounter	3C.1 *Sally Candlin & Christopher Candlin* Presencing in the context of enhancing patient well-being in nursing care	3D.1 *Betina Ringby & Susanne Hjorth Hansen* Laboratory Communication Training in Five Health Care Professions	3E.1 *Karen Livesay, Ruth McNair & Phyllis M. Lau* Use of real stories in cultural sensitivity simulations with simulated patients: necessity or invasion of privacy?
9.30-9.55	3A.2 *Rachel Rowe* Harnessing cultural perspectives to enhance alcohol and other drug treatment	3B.2 *Liz Pryor, Robyn Woodward-Kron & Stuart Marshall* Co-constructing safe patient care: the challenges of intercultural, intra-professional telephone communication	3C.2 *Marit Kvangarsnes, H Torheim, T Hole & S Oehlund* Intensive care unit nurses' perceptions of patient participation in the acute phase of chronic obstructive pulmonary disease exacerbation	3D.2 *Sarah J. White & Israel Berger* Teaching skilled clinical communication: Using audio-visual recordings of actual clinical communication to enhance clinicians' reflective communicative practice	3E.2 *Stella Williams, Farid Youssef & Dexnell Peters* Ethics and professionalism in medical education – Shades of grey?
10.-10.25	3A.3 *Harriet Etheredge, Claire Penn & Jennifer Watermeyer* Communication and cultural factors influencing public attitudes to – and awareness of – organ donation in South Africa	3B.3 *Sascha Rixon, Elizabeth Manias, Allison Williams, Danny Liew & Sandy Braaf* Pharmacists' medication communication with healthcare professionals in speciality hospital settings	3C.3 *Munyane Mophosho* Caregiver problem description in a multilingual and multicultural health care context: Issues and Implications for Speech-Language Therapists	3D.3 *Mei-hui Tsai* Teaching Taiwanese for Medical Purpose: A pragmatic approach to patient-centeredness and dialect preservation	3E.3 *Pamela Snow, Kylie Cocking & Pam Harvey* Fitness-to-Practice concerns in undergraduate medical education: stakeholder perspectives

10.30-11	Morning Break, Ground Floor, Law Building				
10.30-11.25	**POSTER SESSION** (from 10.40) Ground Floor, Law Building, Moderator: **Srikant Sarangi** 1. *Israel Berger & Sarah White* Who's who? Constructing roles during minor awake surgeries 2. *Anne Kalvatsvik, Jan Ole Bolso, Roar Stokken & Johan Barstad* DUGNAD – a communicative model for regional level to support municipalities regarding drug & alcohol use 3. *Henry Kilham* Should children have special ethical consideration? 4. Caitlin Longman, *Claire Penn* & *Jennifer Watermeyer* The influence of isolation and identity on interprofessional communication in a rural hospital 5. *Terry Miller* IMG Communication Skills' Training in Victoria's public hospitals 6. *Johannes H. Österholm & Lars-Christer Hydén* Representing needs in assessment meetings: Persons with dementia applying for formal supportive services 7. *Susan Philip* Intercultural communication in nursing: experiences and training needs of overseas qualified nurses (OQNs) in Australian health care 8. *Daniel McDonald* Building a web-corpus of patients' online mental health communication for mixed-methods investigation				
Room	G08/Auditorium	G27	G29	223	224
Parallel Session 4	**4A Values and Responsibilities** Chair **Bridget Hamilton**	**4B Medical Education** Chair **John Pill**	**4C Work in Progress** Chair **Tim McNamara**	**4D Understanding of Health and Illness / Health Literacy** Chair **Su Yin Hor**	**4E Medical Education** Chair **Liz Pryor**
11.30-11.55	4A.1 *Elizabeth Rider*, Ming-Jung Ho, William Branch Jr., Diana Slade, Jack Pun Kwok Hung, & *H. Esterbrook Longmaid III* Restoring core values: The international charter for human values in healthcare	4B.1 *Maria Dahm*, *Kathryn Ogden*, Lynda Yates, Kim Rooney, *Brooke Sheldon* & *Beth Mulligan* Tag Team – Using an interdisciplinary approach to assess the communication skills of non-native international medical graduates (IMGs) in patient encounters	4C.1 *Matthew Grant*, Jenny Philip, Mark Boughey & *Platon Vafiadis* Exploring community attitudes and beliefs regarding morphine usage in patients with cancer	4D.1 *Mary Wyer* Involving patients in understanding infection control using visual methods	4E.1 *Christine Fairbank* Working as a clinical teaching associate: Women's experiences of teaching sensitive examination

12.00-12.25	4A.2 *Jennifer Philip* Re-thinking the primacy of the patient in the doctor patient consultation	4B.2 *Mahtab Janfada* Employing an 'integrated, dialogic' approach to medical English education in Iran: Toward a clinical pedagogy	4C.2 *Maria Stubbe*, *Lindsay Macdonald*, Ben Gray, Jo Hilder, *Rachel Tester* & Tony Dowell Negotiating role boundaries in interpreter-mediated consultations	4D.2 *Marta Nobile*, Peter J. Schulz & Silvana Castaldi Health Literacy and Empowerment in the context of patients' emergency department use	4E.2 *Kara Gilbert*, Gordon Whyte & Andrea Paul Designing a strategy for articulating clinical reasoning in teaching and assessment: Interpreting the results of a pilot controlled trial OSCE
12.30-12.55	4A.3 *Iréne Josephson* Utilization of patients' resources: A qualitative analysis of missed opportunities in the context of non-specific low back pain and physiotherapy	4B.3 *Sally Warmington* "I don't know how to cut them off": Multi-vocal narrative and the struggle for an integrated professional identity	4C.3 *Kimberley Ivory*, Kim Rooney, Kathryn Ogden & Jennifer Barr How can we improve our understanding and management of ethical issues in community engaged patient-partnership programs?	4D.3 *Marit Kvangarsnes*, H. Torheim, T. Hole & L. S. Öhlund Narratives of breathlessness in chronic obstructive pulmonary disease	4E.3 *Rachel Tester*, Helen Moriarty & *Maria Stubbe* Demystifying addiction through personal stories – An online educational resource
1.00-	Lunch, Ground Floor, Law Building				
1.15-1.55	Health Professional Educator SIG Meeting (Open), Room G14, Moderator: **Rosemary Clerehan**				
Room	G08/Auditorium	G27	G29	223	224
Parallel Session 5	**5A Health Professional – Patient/ Intercultural Communication** Chair **Mahtab Janfada**	**5B Disability / Health & the Life Span** Chair **Robyn O'Halloran**	**5C Consent, Ethics & Communication** Chair **Clare Delany**	**5D Health Professional– Patient Encounters** Chair **Amy Hiller**	**5E Health Literacy / Risk** Chair *Jean Paul*
2.00-2.25	5A.1 *John Pill* An exploratory model of what doctors value in the doctor-patient consultation	5B.1 *Lars-Christer Hydén & Elin Nilsson* Couples with dementia positioning themselves as a 'we'	5C.1 *Jenni Livingston** Parent preferences about the ways information is provided to them for perinatal autopsy consent *** Student bursary prize for abstract**	5D.1 *Elizabeth Manias*, *Allison Williams*, Danny Liew, *Sandy Braaf* & *Sascha Rixon* Pharmacist-patient medication communication on patients' hospital admission and discharge	5E.1 *Marta Nobile*, Peter J. Schulz & Silvana Castaldi Health literacy and empowerment in the context of patients' emergency department use

2.30-2.55	5A.2 *Tim McNamara, Sally O'Hagan & John Pill* Extending the scope of speaking assessment criteria in a specific-purpose language test for migrating health professionals	5B.2 *Cindy Gallois, Rosemary Baker, Daniel Angus, Erin Smith-Conway, Katharine Baker, Andrew Smith, Janet Wiles & Helen Chenery* Visualising conversations between care home staff and residents with dementia	5C.2 *Sally Warmington* "Consent is a bit different with procedures": Fear, desire and identity in narratives of 'customary' consent practices	5D.2 *Danya Vears, Lynn Gillam & Clare Delany* How nondirective are genetic health professionals when parents request genetic carrier testing in healthy children?	5E.2 *Jennifer Watermeyer, Amisha Kanji & Auriette Cohen* Playing it by ear? Caregiver recall and understanding of diagnostic information and assessment feedback in paediatric audiology consultations
3.00-3.25	5A.3 *Lynda Yates, Maria R. Dahm & Sandy McManus* "There is nothing this blue in nature" – Use of informal language strategies among non-native international medical graduates (IMGs) in clinical examinations	5B.3 *Miho Iwakuma* Understanding disability from a communication perspective: A qualitative analysis	5C.3 *Henry Kilham* Increasing deliberate ethics consideration in paediatrics	5D.3 *Claudia Zanini, Paolo Maino, Jens Carsten Möller, Claudio Gobbi, Monika Raimondi & Sara Rubinelli* Five questions to facilitate an agreement with the patient: results from a qualitative study	5E.3 *Carissa Bonner, Jesse Jansen, Les Irwig, Jenny Doust, Paul Glazsiou, Andrew Hayen & Kirsten McCaffery* One size does not fit all: Communication in cardiovascular disease risk assessment and management
3.30	Afternoon Break, Ground Floor, Law Building				
4.00-5.00	Auditorium/G08 Plenary Session II: **Professor Annette Braunack-Mayer, University of Adelaide** *Ethical communication in public health – why we all need a nanny* Chair: Clare Delany				
5.00	Free time				
6.30-7.30	Book Launch: **Communication and Professional Relationships in Healthcare Practice** Sally Candlin and Peter Roger, sponsored by Equinox Upper East Dining Room Room, University House http://maps.unimelb.edu.au/parkville/building/112				
7.30-10.30	Conference Dinner, Matthaei Room, University House				

Saturday 13 July 2013

8.30-9.00	Registration Foyer, Law Building				
Room	G08/Auditorium	G27	G29	223	224
Session 6	6A Medical informatics / Quality of Care Chair *Kris Elliott*	6B Communication Skills / Health Professional–Patient Comm. Chair *Jenni Livingston*	6C Identity & Experiences of Illness Chair *Eleanor Flynn*	6D Written & Interprofessional Communication Chair *Danya Vears*	6E Quality of Care / Ethics Chair *Sally Warmington*
9.00-9.25	6A.1 Tony Dowell, Maria Stubbe, Kathy Scott-Dowell, Lindsay MacDonald & Kevin Dew Talking with the alien: interaction with computers in the GP consultation	6B.1 *Andrea Paul* Discourse, communication and the PR examination: a cross-disciplinary approach to procedural skills teaching	6C.1 *Grace Khunou* Masculine Identity and Access to Health: Perceptions and Experiences of Private and Public Health Services	6D.1 *Jack Pun & Diana Slade* Effective Healthcare Communication in Hong Kong Emergency Departments	6E.1 Claire Penn, Kevin A. Whitehead & Rhona Williams Sources and management of interactional troubles in emergency calls
9.30-9.55	6A.2 *Antoinette Fage-Butler & Matilde Nisbeth Jensen* The impact of email as a communicative medium on the doctor-patient relationship: A literature review	6B.2 Kathryn Hill, Joel King, Andrew Gleason & Eleanor Curran Using role-play based learning to teach undergraduate psychiatry	6C.2 *Carol Rivas, Moira Kelly & Clive Seale* How patient identity is actively shaped within diabetes review consultations and the implications for goal-setting, self-management, and key indicator exploration	6D.2 *Sandra Braaf, Elizabeth Manias & Robin Riley* The role of documents and documentation in the development of communication failure across the perioperative pathway	6E.2 *Clare Delany, Lyn Gillam & M. Spriggs* Obtaining informed consent for paediatric surgery –more complex than it seems
10.00-10.25	6A.3 *Julie Feilberg & Srikant Sarangi* Accounting for loss of life of children in medical records in the 19th century	6B.3 Catriona Fraser, R Woodward-Kron, H Rashid, Yu En Chia, L George, J Au Junior doctors communicating healthcare in culturally diverse rural settings	6C.3 Peter Schulz, Silvia Riva & Uwe Hartung Coping with lower back pain: survey results in the three language regions of Switzerland	6D.3 Debra Griffiths, Julia Morphet, Allison Williams, Tamsin Jones, Kelli Innes & Jo Morey Transferring aged care residents to the emergency department	6E.3 Bridget Hamilton & Cath Roper Ethics & strategies of co-production: academics & consumers sharing expertise in novel research partnerships

10.30-10.55	6A.4 *Andrew Fitzgerald, Ibtissam Shahbal, Robyn Woodward-Kron* Reducing patient complaints about communication in the ED through a communication skills training intervention for junior doctors		6C.4 *Allison Williams & Elizabeth Manias* A qualitative analysis of people's motivation and confidence in taking multiple prescribed medicines	6D.E *Su-yin Hor* Accounting for patient safety through multiple accountabilities	6E.4 *Margareta Hydén* The Teller-Focused Interview: Interviewing as a Relational Practice
11.00 11.25	Morning Break, Ground Floor, Law Building				
11.30-12.30	Auditorium/G08 Plenary Session III: **Professor Arthur Frank, University of Calgary** *Reflective Writing, Clinical Training, and the Power of Stories* Chair: Marilys Guillemin				
12.30 12.45 1.00	Auditorium/G08 Publishing Healthcare Communication and Ethics Research: **Professor Srikant Sarangi** COMET 2014, Lugano, Switzerland: **Professor Peter Schulz** Conference Close				
1.00-1.30	Lunch, Ground Floor, Law Building				
1.30-3.00	**Indigenous walking tour of University of Melbourne Campus** (meet at registration desk) with Mr Charles Solomon, University of Melbourne ***Billibellary's Walk*** A cultural interpretation of the landscape that provides an experience of connection to country which Wurundjeri people continue to have, both physically and spiritually.				

Thursday July 11th 10:00 am

Professor Fernando Martin Sanchez

Melbourne Medical School & Melbourne School of Engineering, The University of Melbourne

Participatory health: the role of informatics and implications for the patient-physician encounter

Recent advances in technologies such as the social web, mobile devices and smartphones, games and sensors are giving rise to a wave of innovation in which patients can take more responsibility for the maintenance of their own health and demand a more active role in the processes of clinical decision making concerning them. This area is known as participatory health. It is based on the availability of information processing tools that let patients collect data about their own health, manage this information, share it with colleagues or with clinicians and even analyse it to gain knowledge that could help them to improve their health. Some of the successful experiences in this domain report that they contribute to more preventive approaches through improved risk profiling, better models of disease prediction and control of health system costs. Medicine should not miss this opportunity, although there are still many unknowns. We will particularly discuss the implications of these new approaches for the patient-physician encounter and medical education.

PLENARY SESSION II

Friday July 12th 4:00 pm

Professor Annette Braunack-Mayer

School of Population Health, University of Adelaide

Ethical communication in public health – Why we all need a nanny

Despite the pervasiveness of communication in public health, analysis of its ethical acceptability is only relatively recent. And, until quite recently, most of that analysis has been conducted under the umbrella of debate about that perennial problem in public health ethics: the extent to which the state is justified in limiting people's freedoms in the interests of the health of the public. The dominant metaphor is a 'nanny', representing the state which takes responsibility for meeting all its citizens' needs in an autocratic way.

The nanny metaphor focuses our attention on certain kinds of ethical issues in public health communication, but it allows us to ignore other issues. For example, we tend to ask: To what extent is it acceptable to use communication strategies which manipulate people into making healthy choices? or, Are authoritarian messages ever appropriate for public health? Ethical analysis of non-coercive health communication is much less common (Rossi and Yudell 2012).

In a parallel way, how we interpret the nanny metaphor itself is shaped by the inclination in public health ethics to regard every problem simply as an exercise in conflict resolution between the needs of the state and those of individuals. Here the nanny is always represented as overprotective and dictatorial. But, what if we were to attend to other aspects of being a nanny when we defined and analysed ethical issues in public health communication?

This paper plays with the nanny metaphor as a vehicle for articulating ethically acceptable communication in public health. By linking answers to the question 'what makes a good nanny?' with empirical research on communication during school closures in a pandemic, in mass

immunisation programs and in public health research, I explore what it might mean to communicate ethically in public health.

PLENARY SESSION III

Saturday July 13th 11:30 pm

Professor Arthur Frank

Department of Sociology, University of Calgary, Canada

Reflective writing, clinical training, and the power of stories

During the last decade, North American medical schools have institutionalized requirements in *reflective writing*, generally under a rubric of *professionalism*. A considerable number of journal articles describe these programs, often emphasizing how students are to be evaluated. Communications scholars and ethicists recognize a familiar dilemma when reflective writing becomes a formal requirement with standardized evaluation criteria. On the one hand, reflective writing can be a means of enhancing empathy, ethical self-awareness, and expressive capacities. On the other hand are the familiar neo-Kantian and Critical Theory objections to *instrumentalizing* empathy and ethics by making them graduation credits. Professional medicine is a relentlessly instrumental culture, so it is hardly surprising that reflective writing becomes caught up in that. The issue is whether instrumentalized reflective writing programs does more harm than good to ethical and communicative capacities. The history of the institutionalization of informed consent provides a depressing example of how good ethical intentions can be turned into bureaucratic formalities. My concern is not to criticize existing programs, which are too disparate to admit generalized criticisms. It's more useful to provide a framework for mentoring reflective writing that provides an alternative way of responding to student writing--a *dialogical* response. Rather than treating students' writing as the object of standardized evaluation templates, mentoring sessions would model genuine dialogue. The mentor would utilize questions that draw the student into reflections about what kind of story she or he has told, how it is told, and especially: What kind of *companion* will such a story be, as it shapes the student's future sense of being a clinician? The mentoring questions are based upon two ideas developed in my book, *Letting Stories Breathe* (Chicago, 2010). One is *companion stories*: stories that people retell throughout their lives and

that act as guidance systems in their lives. The questions also apply my distinction between *stories*, which are told individually and are local and contingent (analogous to Saussure's *parole*, Chomsky's *performance*) and *narratives*, which are generalized cultural resources (akin to *langue* and *competence*). It's especially important that students learn to hear how the narrative form within which they tell their stories affects what these stories can tell. To put all this much more simply, the novelist Terry Pratchett writes: "People think that stories are shaped by people. In fact, it's the other way around. Stories exist independently of their players. If you know that, the knowledge is power." In my language, the narrative is what exists independently, but that's a detail. What matters is Pratchett's observation about power. My question is how to teach reflective writing to students in ways that endow them with that power and the wisdom to use it well.

COLLOQUIUM

Thursday July 11th 2:00 – 3:55 pm

Effective communication in clinical interactions: Training and supporting clinicians

Effective communication is increasingly being identified as an essential professional skill for doctors, nurses and allied health professionals to work in the professionally complex and culturally diverse environments of Australian public hospitals. An Australian study of 28 hospitals reviewed the causes of adverse events and found that communication errors were the leading underlying cause, associated with twice as many deaths as was clinical inadequacy (Wilson et al, 1995). In the United States, research suggests that communication breakdowns are the root cause of more than 60 per cent of sentinel events (Joint Commission 2012). There is also no doubt that clinicians themselves regard clinical communication as problematic. Interviews by Arora et al. (2005) of first-year resident physicians about adverse events and near misses related to how patient information was handed over between clinicians found all incidents were the result of communication failures.

The four papers in this colloquium describe the communication skills required in different clinical contexts and explore strategies to better equip clinicians with these skills. The papers cover ward rounds, clinical handovers, mental health team assessment meetings and clinician–patient consultations and involve both experienced and trainee clinicians. The papers are the outcome of the ECCHo project, an ongoing three-year national project into effective clinical communication in handover in different clinical contexts in Australian public hospitals.

The colloquium leader is Suzanne Eggins, Research Fellow (National Linguist) on the Effective Clinical Communication in Handover project, in the Faculty of Arts & Social Sciences at the University of Technology Sydney: suzanne.eggins@uts.edu.au.

Arora V, Johnson J, Lovinger D, Humphrey HJ, Meltzer DO. 2005. Communication failures in patient sign-out and suggestions for improvement: a critical incident analysis. *Quality and Safety in Health Care* 14: 401–407.

Joint Commission 2012 *Root Causes of Sentinel Events*
http://www.jointcommission.org/sentinel_event.aspx

Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Hamilton JD. 1995. The Quality in Australian Health Care Study. *Med J Aust*.1995;163:458–71.

Suzanne Eggins & Diana Slade

Faculty of Arts & Social Sciences, University of Technology Sydney

Interaction: recognising the missing dimension in accounts of clinical handover communication

Research focusing on critical incidents, mortality, risk and patient harm in hospitals has highlighted ineffective communication—including incomplete and unstructured clinical handovers—as a major contributing factor (NSW Health 2005; ACSQHC 2010). In Australia, as internationally, health departments and hospital management have responded by introducing standardised handover communication protocols, such as IS(o)BAR, to guide clinicians in selecting and organising the information they need to hand over (e.g. NSW Health 2010). However, while we recognise that such protocols can help particularly novice clinicians to gather their thoughts before delivering a handover, in this paper we argue that informational problems are only one half of the handover equation and are often dwarfed by problems in the under-researched interactional dimension. We draw on ethnographic observations and transcripts of audio-recorded clinical handovers among medical and nursing teams in the emergency department and general medical ward of an Australian public hospital. We identify interactional problems that range from scheduling handovers in environments that militate against successful interaction through to participants lacking the communication skills to manage dynamic, multi-party interactions. We draw on our background as applied discourse analysts to show the interdependence of (clinical) informational dimensions and (interpersonal) interactional dimensions in achieving effective handovers and to suggest interactional strategies clinicians could use to hand over more effectively. We argue that major improvements in handover communication will not occur until handover is conceptualised as inherently interactive and the consequences of that interactivity are allowed inform handover processes, practices, protocols and training.

ACSQHC (2010) OSSIE Guide to Clinical Handover Improvement. Sydney: Australian Commission for Safety and Quality in Health Care. Available from:

http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-05#

NSW Health. (2005) Clinical Services Redesign Program: Redesigning a better patient journey. Sydney, New South Wales Department of Health.

NSW Health (2010) Improving Junior Medical Officer (JMO) clinical handover at all shift changes—clinician's summary. Sydney, NSW Department of Health.

Edward Stewart-Wynne[1], Michael McComish[1], Fiona Geddes[2], Dorothy Jones[2] & Phillip Della[2]

Royal Perth Hospital, Western Australia[1]; Curtin University, Western Australia[2]

iSoBar as a teaching framework and considerative checklist for clinical rounds in an inter-professional student training ward

Ward rounds are an integral part of patient care, with junior medical officers and allied health professions traditionally taking passive roles in this hierarchically bound clinical routine. While the literature suggests that interdisciplinary collaboration (Halm et al., 2003) and applying systematic approaches to ward rounds (Herring, Caldwell, & Jackson, 2011)result in improved patient outcomes and reduced clinical errors, research identifying suitable training protocols to ease the transition for students from observing ward rounds to actively participating in them is limited (Nikendei, Kraus, Schrauth, Briem, & Junger, 2008). This presentation reports preliminary results of a video reflexive study of ward round practices in the Inter-professional Student Training Ward (STW) at Royal Perth Hospital. Based on the iSoBAR checklist for clinical handover developed for use in the WA public health system, an iSoBAR ward round framework and communication skills training module were developed to assist final year students evaluate and conduct inter-professional ward rounds. Video recordings of STW rounds conducted with and without the iSoBAR tool are compared in relation to common errors and omissions in clinical information, communication quality, information organisation, clinical team involvement and engagement with patients. Indicators of team situational awareness relating to perceived patient deterioration and discharge likelihood are also presented. This study demonstrates how adopting a tool such as iSoBAR can provide students and health professionals with a common structure to logically integrate and communicate patient information and organise clinical tasks in ward rounds, while also promoting student's awareness of the need to engage patients as partners in their own care.

Halm, M., Gagner, S., Goering, M., Sabo, J., Smith, M., & Zaccagnini, M. (2003). Interdisciplinary roundsimpact on patients, families and staff. *Clinical Nurse Specialist, 17*(3), 133-142.

Herring, R., Caldwell, G., & Jackson, S. (2011). Implentation of a considerative checklist to improve productivity and team working on medical ward rounds. *Clinical Governance, 16*(2).

Nikendei, C., Kraus, B., Schrauth, M., Briem, S., & Junger, J. (2008). Ward rounds: how prepared are junior doctors? *Medical teacher, 30*(1).

PAPER III

Marian Lee & Jeanette McGregor

Faculty of Arts & Social Sciences, University of Technology Sydney

The educational benefits of the medical ward round for Junior Medical Officers

Medical ward rounds form an integral part of the teaching process for junior medical officers. In their early years, junior doctors are still in the process of training, and part of the training is integrated with their daily work (Garling, 2008). In a recent pilot study of clinical handover, there was evidence to show that 'senior clinicians are looked to as models and mentors who both legitimise and require particular kinds of practice.' (McGregor, Lee, Slade & Dunston, 2011). Medical ward rounds provide a significant opportunity for senior medical officers to model the exchange of clinical information for junior medical officers, especially those in their first year of practice. Garling also states that the supervision of junior doctors has a positive effect on patient outcomes (2008). In this study of morning medical ward rounds, we examine the opportunities the senior staff missed to promote learning and to teach the junior staff how to synthesise clinical information in ways that will promote better quality care and patient safety.

Garling P. (2008). The Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals. NSW Government, Sydney.

McGregor J, Lee M, Slade D & Dunston R. (2011). Effective Clinical Handover Communication: Improving Patient Safety, Experiences and Outcomes. Pilot Study Report, University of Technology, Sydney.

PAPER IV

John Walsh[1] & Jon Jureidini[2]

Discipline of Linguistics, University of Adelaide[1]; Department of Psychological Medicine, Women's and Children's Hospital, Adelaide & Disciplines of Psychiatry & Paediatrics, University of Adelaide[2]

Clinical communication in the context of mental health

This paper explores the communication challenges and achievements of the mental health team that works as part of the Emergency Department (ED) in a metropolitan public hospital in South Australia. The mental health team's brief is to provide short-term care for mental health patients admitted to the ED and to develop a management plan for each patient's future care. Our research underscores the critical role of communication in the mental health team's achievement of successful outcomes.

Communication between patients and clinicians is a primary means of diagnosing mental ill-health, as clinicians work to understand the mental state of patients from what they do, but also critically from what they say. The mental health team draws on communication between clinicians and any other source of patient information, including family, friends, community mental health professionals and GPs.

Our research explores both intra-team and inter-team communication across the daily cycles of team meetings. We map how the mental health team works together to pool all known and unknown information in its effort to build a shared understanding of each patient's mental state and to piece together a congruent patient narrative. Data taken from different meetings within the daily cycle highlight the uncertainties faced by clinicians and the necessity of shared processes to address complexities. The presentation points to the ways in which the team communicate effectively across the daily meeting cycle to jointly construct coherent patient narratives as the basis for agreement on a management plan.

Michael Arribas-Ayllon

Cardiff University

Decoding a syndrome: interpreting direct-to-consumer genetic tests in online forums

In the last decade, we have witnessed an unparalleled rise of technologies that take a molecular view of disease, health and human potential. The birth of 'personal genomics' – companies that offer direct-to-consumer genetic testing – is a controversial development in contemporary biopolitics. The main concern is whether genetic technologies that promise the power of prediction can deliver a truly 'personalized medicine'. Access to groups who use these services is difficult, and yet we are beginning to see online traces of people engaging in highly technical forms of information sharing. In this paper, I present some preliminary findings of an online community who are using SNP data to make sense of an ill-defined condition, Chronic Fatigue Syndrome (ME/CFS). From a molecular perspective, CFS is redefined as a 'complex' condition, comprising genetic susceptibilities which are regulated by environmental factors such as stress and toxic exposure to nutrients and chemicals. Genetic testing provides the means of identifying susceptibilities that lead to 'neurological inflammation', i.e. the overexcitation of neurons and nerve pathways in the central nervous system. Analysis of forums reveals a range of discursive and relational practices for aggregating, sharing and interpreting genetic information as well as engaging in forms of advice-giving for the management of hope and wellbeing. Emerging strategies of reduction, clarification and interpretation provide a means of asking to what extent these practices reveal the geneticization of a syndrome, novel forms of biosociality and new ways of relating to ourselves as 'somatic' individuals.

Johan Barstad[1,2], Siv R. Osdal[1], Solrun Osdal[1] and Roar Stokken[1]

Møre and Romsdal Hospital Trust[1]; The Norwegian University College for Agriculture and Rural Development[2]

Left hanging in mid-air: Patients experiencing complex return journeys from hospital

Background and objective of the paper: Modern healthcare centralises complex treatment procedures to larger regional and national hospitals. The transfer generally involves long distances; still the patient is continuously in the care of qualified personnel. Returning to home becomes a long and complex journey, generally involving several means of transportation and having to travel by themselves, at best accompanied by a traveling companion.

Methods: In 2006-08 we performed a local study regarding information to patients experiencing cardiac arrest, including a transfer to regional hospital for treatment, through a survey (N 99, reply 72%) to all patients in this group at two local hospitals, and 6 in-depth interviews to a sample of the surveyed patients. The survey analysed using SPSS (Chi‑ square tests) and the interviews transcribed, categorized and analysed using Hyperresearch. Findings Patients who experienced inadequate information regarding the return journey had negative experiences of the journey. Patients, who experienced information adequate, generally reported more positive experiences. The positive effect of a traveling companion was significant. Returning home the patients crosses between two care systems. Information between the two care-system levels was inadequate. This has direct implications to current policy-development in Norway, where issues of coordination between the two levels are primary target.

Implications: No results show any adverse healthcare effects from lacking information. Negative experiences influence the general experience of the healthcare system. This might easily be remedied through better information routines. We conclude that more focus on information about the homeward journey may contribute positively to the general trust in the Norwegian healthcare system.

Katja Beitat

University of Leipzig, Germany

The role of trust between medical practitioners and patients after medical incidents

In the delivery of health care, trust on various levels is essential. Concentrating on interpersonal trust between medical practitioners and patients, trust is defined using a dynamic model that illustrates the link between communication and relational qualities in the patient-provider interaction. At its core, the relation between medical practitioners and patients, including the quality of constant verbal and non-verbal dialogue, enable, but may also destroy trust.

Medical practitioners are unique insofar as due to their professional role and the values ascribed to it, most patients trust a doctor even without prior interaction. The presentation explores the generic role of trust between medical practitioners and patients in routine interactions before continuing to look at the development of both the relationship and the dynamics of trust after something goes wrong in the treatment or care of a patient.

After an incident, trust may be jeopardised. At the same time, trust becomes essential for the continuation of the doctor-patient relationship at a time of unexpected outcomes. Using the results from an interview study with patients and medical practitioners and from a survey among medical practitioners about their attitudes and experiences with medical errors, the presentation will analyse the role they ascribe to trust and the circumstances that influence trust levels.

The presentation will summarise the findings about how trust can be maintained even after health care incidents, and will place it into the context of how open disclosure can be implemented successfully.

Beitat, K, Bentele, G & Iedema, R (2012): Trust after medical incidents. In: Candlin, CN, Chrichton, J (eds.), *Discourses of trust.*

Palgrave Studies in Professional and Organizational Disclosure. Palgrave Macmillan, p. 77 -95.

McLennan, S, Beitat, K, Lauterberg, J & Vollmann, J (2012): Regulating open disclosure: a German perspective*. International Journal for Quality in Health Care*; Volume 24, Number 1: pp. 23–27.

Carissa Bonner[1], Jesse Jansen[1], Les Irwig[1], Jenny Doust[2], Prof Paul Glazsiou[2], Andrew Hayen[1], Kirsten McCaffery[1]

Sydney School of Public health, The University of Sydney, Sydney, NSW, Australia[1]; Faculty of Health Sciences & Medicine, Bond University, QLD, Australia[2]

One size does not fit all: Communication in cardiovascular disease risk assessment and management

Background: Cardiovascular disease (CVD) prevention guidelines advocate the assessment of absolute risk (AR) - the probability of a cardiac event over a period of time, based on multiple risk factors. However, research has shown that most general practitioners (GPs) do not use AR, and communication difficulties have been identified as a barrier to changing practice. The aim of this study was to explore GPs' experiences and identify communication strategies and challenges.

Methods: Semi-structured interviews were conducted with a purposive sample of 25 GPs. Transcribed audio-recordings were coded for themes using framework analysis.

Findings: Most GPs had used AR, but did not use it consistently. GPs used a range of strategies to communicate CVD risk depending on patient characteristics. Patient motivation was a key factor, with GPs tailoring their approach to patients' readiness to change. A more directive approach was used for high risk and less motivated patients, particularly males and smokers. AR was used to 'scare' patients into taking action and show patients how they could reduce risk, but was sometimes withheld from highly anxious patients. The biggest communication challenge was convincing asymptomatic patients that they have a health problem and may need to take medication.

Implications: GPs in this study did not perceive difficulties in communicating to patients about their CVD risk, although most did not use AR consistently. GPs tailored their communication approach based on risk level and psychosocial factors, particularly motivation, anxiety, and resistance to change, suggesting that communicating CVD risk in a "one-size-fits-all" way is ineffective.

Sandra Braaf, Elizabeth Manias & Robin Riley

The University of Melbourne

The role of documents and documentation in the development of communication failure across the perioperative pathway

Background: Communication practices of healthcare professionals have been strongly implicated in the development of events that unfold into poor outcomes for surgical patients. This presentation provides insights into the role of documents and documentation in shared decision-making and the development of communication failure as information is transferred across the perioperative pathway.

Methods: This institutional ethnographic study incorporated the use of structured and unstructured observations, focus groups, patient interviews and survey distribution as research methods. Healthcare professionals of different disciplines were purposively sampled from diverse perioperative areas in 3 public metropolitan Melbourne hospitals. Analysis through institutional ethnography involved examining communication influences, encounters and outcomes through tracing social relations and coordinating healthcare professionals' work practices.

Findings: Information from over 350 observation hours, 2 focus groups, 20 interviews and 281 survey responses were collated. Healthcare professionals' communication across the perioperative pathway was problematic as documents and documentation were used to replace verbal interactions, and documentation was routinely incomplete, inaccurate and out of date. Further, time restrictions impeded healthcare professionals from extracting information buried in masses of documentation. Limited information-sharing and impaired decision-making occurred, potentially compromising patient safety.

Implications: To promote shared decision-making and reduce the incidence of communication failure, healthcare professionals need to be afforded the time to perform documentation and view documents. Further, updated information technology communication systems are required to ensure timely document and documentation availability.

Sally Candlin & Christopher N. Candlin

Macquarie University, Sydney

Presencing in the context of enhancing patient well-being in nursing care

Drawing on a single narrative of experience of a skilled nurse engaging with a patient approaching the end of life, this paper explores how critical moments in this crucial site of engagement (Scollon,1998,2001) may be collaboratively managed, discursively and professionally, with the enhancement of the health and well-being of the patient in mind. The paper lays emphasis on the holistic understanding of the interactional context by both nurse and analyst, emphasising the patient's physical, spiritual, social and emotional condition. Such an understanding may be captured by the construct of '*presencing'* (Fredrickson, 1999; Candlin, 2008; Walsh, 2009) as a key factor in understanding patient and nurse identities and contributing to accounting for professional nursing expertise. In the context of practitioner professional development, the paper further explores contrasting approaches to the analysis of professional narratives (Riessman, 1990a, 2002; De FIna & Georgakopoulou, 2008, Bamberg et al, 2007) and argues that achieving such professional expertise should extend beyond 'skills training' to involve a situated data-driven cycle of Awareness, Knowledge, Critique and Action.

Bamberg, M., de Fina, A., & Schiffrin, D. (2007) *Selves and identities in narrative and discourse*. Philadelphia, PA: John Benjamins.

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Fredrickson, L. (1999) Modes of relating in a caring conversation: a research synthesis on presence, touch and listening *Journal of Advanced Nursing* 30 (5) (1167-1176)

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Riessman, C.K. (2002) *Illness narratives: positioned identities*. Invited Annual Lecture. Health Communication Research Centre, Cardiff University (May) (unpublished)

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Scollon, R. (2001) Action and text: towards an integrated understanding of the place of text in social (inter)action, mediated discourse analysis and the problem of social action. In R.Wodak & M.Meyer (Eds)(2001) *Methods of critical discourse analysis*. London. Sage (139-184)

Walsh, K.M. (2009)) *Disciplined silence: a focused ethnography of exemplary emergency nursing practice.* Dissertations Collection for University of Connecticut. Paper accessed AA133677468888.http://digitalcommons.uconn.edu/dissertations AA133677468.

John Cartmill & Maria R. Dahm

Macquarie University, Sydney

"When the wheels fall off." – Making use of overlaps in communicative strategies between obtaining informed consent and breaking bad news

Background: Doctors rely on a variety of "set pieces" to help them to transfer certain types of information to their patients. *Breaking bad news* is a well-known and well-researched "piece" typically taking place after a procedure has resulted in unexpected or unwanted outcomes. The potential for such complications are usually communicated through another "set piece" - *informed consent* - in earlier consultations. As with all communicative acts, the language used while obtaining informed consent greatly influences patients' understanding of the risks involved in a procedure and the type of relationship formed between doctor and patients. Yet, potential overlaps in the communicative strategies used in both of these "set pieces" remain largely unexplored.

Methods: This paper examines the language used in obtaining informed consent in relation to that used in breaking bad news. Drawing from a wealth of experience in gastro-intestinal consultations, it is argued that obtaining consent is in fact a type of breaking bad news and it is explored how recognizing the importance of informed consent can increase patient safety.

Findings: It is shown that by adopting communication strategies usually employed in breaking bad news, the communicative act of obtaining informed consent can help to build trusting relationship with patients and their families, and can thus provide a strong foundation to prepare patients for and to manage potential future complications.

Implications: This study illustrates that obtaining informed consent and breaking bad news can be framed as overlapping communication acts, offering doctors a wide range of communication resources which could become invaluable in communication training for medical students.

Rosemary Clerehan[1], Catherine Elder[2], Margaret Staples[1,3], Richard Osborne[4], Rachelle Buchbinder[1,3]

Monash University, Australia[1]; The University of Melbourne[2]; Cabrini Institute[3]; Deakin University, Australia[4]

Medical terms in patients' words: implications for clinical communication

Background: Clinicians routinely use terms which may or may not be understood by patients. It is a constant challenge to describe diagnoses and prescribe treatment for patients when there is uncertainty as to what degree terminology is understood. Most widely used health literacy measures claim to measure patients' ability to understand health related information, but the precise nature of this understanding is seldom probed.

Methods: As part of a study evaluating the REALM (Rapid Estimate of Adult Literacy in Medicine), a widely used measure which claims to predict health literacy based on individuals' ability to pronounce common medical and lay terms, we presented 310 respondents (drawn from the Victorian electoral roll) with a subset of 13 terms and asked them to read them aloud and then provide oral definitions/explanations. The quality of these explanations was independently rated on a 0-2 point scale by to medical researchers and an applied linguist.

Findings: While most participants could pronounce the words correctly, only 6/320 (1.9%) defined all 13 words correctly. Of participants who scored highly on the REALM, less than half scored in the top range for definitions. Examples of common misconceptions emerging from the data are offered to illustrate the nature of patients' misunderstandings.

Implications: Clinicians need to realise that patients, while pronouncing (and even using) medical terms correctly may have a quite limited, or erroneous, understanding of the meaning. This can lead to potentially dangerous assumptions about the extent of the patient's participation in the healthcare partnership.

Maria R. Dahm[1], Kathryn Ogden[2], Lynda Yates[1], Kim Rooney[2], Brooke Sheldon[2] & Beth Mulligan[4]

Macquarie University[1]; Launceston Clinical School, University of Tasmania[2]; Launceston General Hospital, Launceston, Australia[4]

Tag Team – Using an interdisciplinary approach to assess the communication skills of non-native international medical graduates (IMGs) in patient encounters

Background and objective: International medical graduates (IMGs) make up a quarter of the Australian medical workforce. While many face considerable cultural and communication barriers, there is little targeted support available to them. The few existing training modules rely largely on medical educators to provide medical *and* communication feedback, leaving IMGs with generic comments that offer only little help to improve their communication skills. This interdisciplinary study combines perspectives from applied linguistics with insights from clinical medical educators and allows us to address IMGs' difficulties from multiple dimensions.

Methods: Five video-recorded patient encounters with 5 IMGs were collected at Launceston General Hospital and analysed quantitatively and qualitatively for medical competence using the "Rating Instrument for Clinical Consulting Skills (RICS)" tool by three clinical educators, and for language, pragmatic and communication difficulties by two applied linguists. The medical educators' language-related feedback was compared to the communication issues observed in linguistic analysis of the same interactions

Findings: Comparisons of analyses from experts with different backgrounds allowed researchers to explore whether any inconsistencies exist regarding the language difficulties identified by medical educators vs. applied linguists. Subsequent analysis focused specifically on more subtle aspects of language associated with good communication skills, which medical educators can often address superficially but where underlying linguistic and pragmatic difficulties are less salient to them.

Implications: This pilot study illustrates the importance of interdisciplinary collaborations to increase our understanding of intercultural health communication and to ascertain how medical educators could benefit from linguistic insights to provide more specific feedback on IMGs' communication skills.

Clare Delany[1,3], Lynn Gillam[2,3] & M. Spriggs[3]

School of Health Sciences, University of Melbourne[1]; School of Population Health, University of Melbourne[2]; Children's Bioethics Centre, Royal Children's Hospital, Parkville, Australia[3]; Murdoch Children's Research Institute[4]

Obtaining informed consent for paediatric surgery –more complex than it seems

Background: The typical model of informed consent for invasive medical procedures involves one main surgeon who discusses benefits, risks and alternatives of surgery with an adult patient. This becomes more complicated in the paediatric setting where the patient is a child and parents must consent on their behalf. Further complexity arises if surgery is a separate but necessary component of a set of treatment procedures, and the doctor doing the procedure is not the main treating doctor. An example is the insertion of a central venous access device in children, commonly performed when a child requires drugs that are only suitable for central venous infusion (such as chemotherapy), or when the duration of therapy is likely to exceed 7 days.

Method: We use role plays of typical requests for central venous access devices to highlight ethical and legal areas of uncertainty of informed consent for this surgery. These include how much needs to said about an apparently minor part of treatment for a major illness such as cancer, who should talk with parents and seek consent when different procedures are being done by different doctors, all as part of the treatment for one condition. The role plays are derived from interviews with 6 parents whose children received a central catheter, and 4 anaesthetists who regularly perform this procedure.

Conclusion: We propose a set of legal and ethical principles to guide the informed consent conversation based on insights from interviews,and a review of the clinical, legal and ethical literature about informed consent in paediatric surgery.

Tony Dowell[1], Maria Stubbe[1], Kathy Scott-Dowell[1], Lindsay Macdonald[1] & Kevin Dew[2]

Department of Primary Health Care and General Practice, Wellington School of Medicine and Health Sciences, University of Otago, New Zealand[1]; School of Social and Cultural Studies, Victoria University of Wellington, New Zealand[2]

Talking with the alien: interaction with computers in the GP consultation

Background/Objectives: The routine use of electronic health records in general practice has led to improved clinical outcomes. However, computer use inevitably affects the nature and quality of GP-patient communication. This paper explores how GPs manage the increased interactional complexity that results from integrating the computer into consultations.

Methods: 28 video-recorded consultations were analysed to establish: how doctors divided their time/attention; the different roles of the computer in the consultation (e.g. information source or repository, legitimiser of actions); whether individual GPs had distinct styles of computer use; and how the computer influenced the overall shape and interactional flow of the consultation.

Findings: All GPs engaged with the computer in some way for at least 20% of each consultation, and 12% of their time on average was spent totally focused on the computer. However, there was individual variation: some GPs inputted all notes during the consultation while others set aside dedicated time afterwards. Length of consultation and amount of computer-focussed time were positively correlated. Computer use altered some of the normal 'rules of engagement' between doctor and patient, often resulting in long silences and procedural talk to smooth over interruptions to the conversation (e.g. *I'll just go back into my computer*). GPs also used various 'multi-tasking' strategies to remain engaged with the patient during episodes of computer use (e.g. online commentary, verbalising information while typing, social chat, touch typing).

Implications: The use of computers significantly influences the fine detail of the GP consultation. Doctors must consciously develop strategies to manage this impact.

Jaklin Eliott[1], Ian Olver[2] & Annette Braunack-Mayer[1]

School of Population Health, University of Adelaide[1]; Cancer Council Australia[2]

When one of us gets cancer: the enduring impact on the family

Background: A cancer diagnosis has a profound effect on the affected family, and some experience increased distress. The number of cancer 'survivors' has increased significantly, but little is known about the psycho-social impact upon the 'survivor' family.

Method: 23 self-defined families (53 total participants) of cancer survivors (12 > 3-years post-diagnosis) were recruited through Australian media and participated in a family interview about enduring challenges post-treatment. Interviews were recorded, transcribed verbatim, then thematically-analysed.

Findings: Participants noted or exhibited various long-term outcomes of a cancer diagnosis within their families, including: a) challenges in managing changes in their working life and geographical location; b) that the physical effects of cancer and treatment changed what they could do as a family; c). problematic relationships with external family members due to disagreements regarding choices; d) difficulties in managing their own or others' emotions, or in adjusting to changes of personality or priorities exhibited by the diagnosed individual; and e) conflict regarding management of risk factors: views about the importance and consequences of behavioural change to manage risk varied, causing on-going tension. These (relatively high-functioning) families faced psycho-social challenges long after diagnosis. Cancer changed the present circumstances, future possibilities, and individuals' identities. Communication problems and conflict appeared to reflect unspoken beliefs about the needs, rights, and responsibilities of different family members.

Implications: Further analysis of familial interaction following a cancer diagnosis might usefully explore differences in assumptions; the opportunity to clarify values and expectations for and within such families may reduce miscommunication and subsequent distress.

Harriet Etheredge, Claire Penn & Jennifer Watermeyer

Health Communication Research Unit, School of Human and Community Development, University of the Witwatersrand, Johannesburg, South Africa

Communication and cultural factors influencing public attitudes to – and awareness of - organ donation in South Africa

Background and objective of the paper: There has been an unexpected decline in organ transplants in South Africa over the past decade. The present study aims to explore possible reasons for the decline and the influence of communication, cultural and contextual factors on shaping or changing public attitudes about organ transplantation.

Methods: A structured, interviewer-administered questionnaire was utilised to measure attitudes amongst a study population of 1048 adults in five major metropolitan areas of South Africa. Field work was undertaken by trained field workers and supervised by field managers. Written informed consent was obtained from all participants. Data were captured, cleaned, converted into SPSS format and analysed using SAS Version 9.3.

Findings: The majority of the sample expressed positive attitudes toward organ donation. 89% had heard of organ donation, with television being the most effective means of communicating information to the public. Several language and cultural barriers emerged in the dissemination of information and in communication. These also influenced willingness to consider organ donation.

Implications: The research suggests that public education campaigns for organ donation and awareness in South Africa should be reconsidered in terms of language and cultural factors, especially amongst certain population and language groups. Communication through television should be emphasised. The findings of the study present implications for intercultural-communication practices and policy regarding organ donation, which will be discussed.

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The impact of email as a communicative medium on the doctor-patient relationship: A literature review

Background and objective: Although theoretical perspectives on the doctor-patient relationship have characteristically assumed the temporal and physical co-presence of doctor and patient, the advent of email in doctor-patient communication has brought with it a different communicative reality. New technologies come with significant implications as, amongst other things, they impose practices and identities on participants (Malater 2007). The purpose of this integrative literature review is thus to investigate how the advent of email as a medium of communication affects the doctor-patient relationship.

Methods: Using the methodology of the integrative literature review (Whittemore and Knafl 2005), 38 articles identified from database searches from 2002-2012 are grouped and evaluated under three headings: the content of email exchanges, patients' perspectives on email communication and doctors' perspectives on email communication.

Findings: Analysis reveals that greater enthusiasm is generally more evident amongst patients than doctors for email as a medium of communication. Patients identify numerous advantages with email including the possibility of greater empathy due to the informality of the medium, convenience, freedom from the clinical gaze, pseudo-anonymity and greater opportunities for reflection, whilst doctors express concerns about confidentiality, time and the challenge of conveying empathy electronically.

Implications: The impact of email on the doctor-patient relationship has hitherto been addressed obliquely, indicating the need for more research in this area. Empirical work could also valuably support the development of theories that would reflect this new communicative reality, replacing outdated ones.

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Working as a clinical teaching associate: Women's experiences of teaching sensitive examinations

Background: Clinical Teaching Associate (CTA) programs have existed overseas since the 1980s with the University of Melbourne program first developed over 10 years ago. Our female CTAs are trained to teach students the technical, and communication skills needed for a patient centred examination. Professional patient programs are important approaches to teaching students to perform sensitive examinations but are rarely the subject of research. In particular, we know little of the experiences of women working as CTAs.

Methods: Twelve CTAs volunteered to be interviewed for the research, by an interviewer independent of program administration. Interviews comprised ten broad questions designed to elicit women's experiences of joining the program and their motivation to continue teaching in the program. They considered challenges they encountered and benefits they derived from participating.

Findings: CTAs interviewed tended to share health or education backgrounds, and an interest in improving women's health. They regarded the CTA role as requiring skilled communication, sensitivity and self-awareness, a capacity to give feedback and to work in a team. They valued other CTAs, while recognising difficulties with team dynamics and giving negative feedback to colleagues. Most women expressed positive feelings about the value of their work, but found it difficult to be open about discussing their work with others as many had encountered negative attitudes.

Implications: Exploring the experiences of CTAs is important in highlighting and validating the experiences of women undertaking this

essential work, as well as gaining greater understanding of the motivations of women for joining and remaining in the program, so recruitment and support may be better targeted.

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Accounting for loss of life of children in medical records in the 19th century

There is a well-established body of literature devoted to the study of medical records (also referred to as patient records) in both primary and tertiary healthcare settings. In such records, to use Mishler's terminology, the voice of medicine routinely prevails over the voice of the lifeworld as fellow professionals are oriented to as the target readership.

In this paper we examine the medical records written over approximately 100 days by a doctor on board the German ship Lammershagen carrying 420 European immigrants, on sail from Hamburg to Wellington, New Zealand, in 1875. As contextual background, the medical records embodied a duality of purpose: the doctor maintaining a day-to-day record of the 'ill' passengers as well as the records serving as a document to testify to the New Zealand immigration authorities the health status of the immigrants on arrival (including loss of life and newborns during the voyage).

A striking feature of these medical records is the longitudinal entries involving children, resulting in either loss of life or cure. Our discourse analytic focus is on the motivated interplay of the voice of medicine and the voice of the lifeworld (including assessments of parental responsibility) in the doctor's accounting practices across 'loss of life' and 'cure' scenarios (totalling six longitudinal cases). Our preliminary findings suggest that, unlike in 'cure' cases, in the 'loss of life' cases the voice of the lifeworld is more pronounced and the voice of medicine is more detailed. In light of the medical record's duality of purpose, we argue that the doctor's accounting practices were anticipating the need for a justification of the ship's 'ins and outs' to the New Zealand immigration authorities.

Catriona Fraser[1], Robyn Woodward-Kron[1], Hashrul Z. Rashid[2], Yu En Chia[2], Leah George[2] & Jonathon Au[2]

Medical Education Unit, University of Melbourne[1]; Goulburn Valley Health, Shepparton, Australia[1]

Junior doctors communicating healthcare in culturally diverse rural settings

Background: In Australia, junior doctors working in public hospitals are Australian born graduates, overseas born Australian graduates, and International Medical Graduates (IMGs). In Victoria, these graduates are delivering healthcare in a context where more than 20% of the population speak a language other than English at home. Miscommunication between clinicians and patients can occur when there are differences in language and culture including participants' expectations about healthcare. This study investigated the effectiveness of junior doctor-patient communication in a culturally diverse rural setting; it sought to identify communication challenges, effective strategies as well as areas for improvement.

Methods: A case study, qualitative design was adopted. The data were 5 focus group interviews with 20 junior doctors; interviews with 9 senior doctors, and 4 senior professional staff as well as 5 audio-recorded interactions between junior doctors and patients. The setting was an emergency department in a rural hospital in Victoria. The interviews and focus groups were analysed thematically; the doctor-patient interactions by discourse analysis.

Findings: The findings from the interviews and focus groups suggest that while junior doctors have some strategies to overcome communication challenges in the ED, such as language barriers, they can struggle with cultural differences in patient expectations of healthcare and expression of symptoms. Senior medical staff reported that there is room for improvement, particularly in explaining the diagnosis and management plan.

Implications The findings will inform intern orientation, alerting junior doctors to the communication needs of culturally diverse rural patients.

Cindy Gallois[1], Rosemary Baker[1], Daniel Angus[1], Erin R. Smith-Conway[1], Katharine S. Baker[2], Andrew Smith[1], Janet Wiles[1] & Helen J. Chenery[1]

University of Queensland[1]; Stanford University[2]

Visualising conversations between care home staff and residents with dementia

Background: People with dementia in residential care face the disadvantage of communication difficulty and reduced opportunities for conversation. Social interaction is central to their wellbeing, so care staff require specialised skills to engage them in conversation. We used Communication Accommodation Theory, along with a new visualisation technology, to elucidate the language engagement in conversation between carers and residents with dementia

Method: We studied 20 carer-resident dyads, examining conversational structure and content, patterns of engagement, and communication by care staff that facilitated or impeded residents' participation. The transcripts were analysed using Discursis, a computational information visualisation tool that allows interactive visual inspection of language, turn-taking dynamics, and content recurring within and between speakers.

Findings: The conversations differed in extent to which the staff member led the conversation and how much the resident engaged with it. We present Discursis results and our interpretations for case examples: (1) where care staff did most of the talking and led the conversation; (2) where talk was more evenly shared between partners; and (3) where participants with dementia talked most. We identified accommodative strategies used by care staff, such as reflecting the other person's responses to sustain engagement, as well as behaviours that impeded communication, such as not listening attentively or allowing sufficient time for responses.

Implications: This research shows that, even with very severe dementia, one can gain engagement, depending crucially on the extent of

accommodation used by carers. There are immediate implications for training, both of residential care staff and of home-based carers.

Kara Gilbert, Gordon Whyte & Andrea Paul

Monash University, Australia

Designing a strategy for articulating clinical reasoning in teaching and assessment: Interpreting the results of a pilot controlled trial OSCE

Background/Objective: A clinician and two linguists collaborated on the design and delivery of a pilot program to teach a group of third year medical students strategies for articulating clinical reasoning and decision-making, with students participating in a two-station formative OSCE on conclusion of the program. Study objectives were to: (a) Assess the impact of the program on students' performances on a formative OSCE; (b) Compare 'clinical reasoning' (Examiner B) and 'traditional' (Examiner A) assessment of the OSCE, analysing students' discourse strategies and clinical knowledge based on previous EMQ formative assessment; and (c) Evaluate students' experiences of the program.

Methods: Fifteen Year 3 medical students were selected into control (7 students) and intervention (8 students) groups, the latter attending the pilot program. All students participated in a video-recorded two-station formative OSCE. OSCE dialogues were transcribed and discourse analysed for: linguistic markers of argument and reasoning, and text macrostructure and superstructure.

Findings: Students must acquire a complex integration of content knowledge and logical sequences in their elaboration of disease, diagnosis and management. While the teaching intervention did not show a significant impact, linguistic features of argument generally were linked with higher assessment ratings. Students rated the intervention highly, providing feedback useful for curriculum development. Comparisons between EMQ and OSCE measures showed a discord between the assessment of content knowledge and clinical reasoning skills, with checklist criteria emphasising content knowledge over and above reasoning ability. Students and examiners would benefit from an explicit rather than implicit awareness of the language and communication strategies for conveying clinical reasoning.

Implications: As this work is intended to inform undergraduate medical curricula, challenges of integrating interdisciplinary perspectives into clinical communication pedagogy and the training of examiners in new systems of assessment criteria will be discussed.

Natalya Godbold & Marie Manidis

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Collaborating healthcare knowledge: knowing online and in emergency departments

Medical knowledge is assumed to be the expert domain of clinicians. This paper compares patients' use of medical knowledge in two different settings: as they interact with practitioners in emergency departments and between peers in online forums. In particular, we explore ways that patient and clinician knowledges are valued, negotiated and understood by patients over time. We compare the relative valuing of patient versus clinician knowledge, and the relational underpinnings of how knowledge is done (and/or not done) together (Gergen 1985).

First, we use ethnographic and linguistic ethnographic methods to analyse discursive and clinical practices from a four year study in emergency departments, showing how patients compete with clinicians to have knowledge of their illnesses recognised as legitimate for inclusion in diagnosis and treatment decisions. We compare those findings with a separate analysis of how patients negotiate knowledge about kidney disease with their peers, based on a two year ethnomethodological involvement with online forums. We use thematic analyses to identify forms of authority unavailable to clinicians, describing how patients swap underground perspectives and tactics for living with chronic illness. Drawing on the findings from both studies, we explore implications for health care provision, given that patients and clinicians need time to develop understandings, and must collaborate to do so. We expressly include the patient as an actor in health care. We conclude with implications for communication in clinical practice, proposing ways that clinicians might more productively perceive and support patient knowledge(s), and thus better facilitate collaborated health care.

Debra Griffiths, Julia Morphet, Allison Williams, Tamsin Jones, Kelli Innes & Jo Morey

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Transferring aged care residents to the emergency department: the legal and ethical issues underlying communication

Background: In June 2010 there were approximately 182,825 people living in residential aged care facilities in Australia, 75% of whom were in high level care. This group epitomize the sickest and most vulnerable members of our community. Aged care residents are prone to chronic illness including dementia, with co-morbidities which frequently require transfer to acute care services. Many residents arriving to the Emergency Department (ED) from Residential Aged Care Facilities (RACF) are not able to convey their needs or treatment wishes sufficiently. In order to adequately care for residents, ED staff require accurate and complete health information. The transfer process depends upon clear communication between multiple health professionals. Written documentation is the primary means of communication on which the ED team base patient management.

Aim: This paper intends to identify the legal and ethical issues in relation to documentation accompanying aged care residents transferred to the Emergency Department.

Method: A retrospective audit of de-identified records of residents transferred from aged care facilities in 2012 was undertaken using ED electronic patient medical records. The sample size reflects 10% of all transfers from RACF to the two metropolitan hospitals.

Findings and Implications: The study sought to explore the documentation in relation to the prevalence of unnecessary treatment, investigations and inefficient patient management. It is intended that the research findings will guide specific recommendations to improve communication between treating staff to make decisions to avoid unnecessary or unwanted investigations. This will improve ED efficiency while ensuring decisions are congruent with patient wishes.

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Empowering strategies in children's diabetes consultations with doctors and immigrant parents

Background and objective: This paper will report findings from a case study, performed at two children's diabetes clinics in Sweden, contributing to an understanding of communicative strategies used by health care professionals, interpreters and immigrant parents of children with diabetes. It can be argued that linguistic competence and efficient communication is a prerequisite for the process towards empowerment. Linguistic competence is crucial not only to understand the details of the care, but also to be affected by the conscious language use of health care professionals to encourage and strengthen the patient. It is therefore important to investigate the use of empowering strategies in encounters with immigrant patients or parents. In this paper, I will discuss empowering strategies in encounters with and without interpreter.

Method: Consultations were video recorded and followed by stimulated recall interviews. Four recordings were fully transcribed using the chat-format, and a linguistic analysis of communicative strategies was performed.

Findings and implications: Linguistic realizations of "empowering counselling" (Kettunen et al. 2001), such as active listening techniques, questions, hedging, hesitating speech etc. are differently distributed in encounters with or without interpreter. The strategies (some also referred to as politeness strategies, Brown & Levinson 1987) are features in the consciously chosen conversation style of health professionals. One of the conclusions of this study is that an interpreter will need not only to be aware of the translation of word meaning, but also to be educated in what subtle effects can be reached by the choice of conversation style.

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Ethics & strategies of co-production: academics & consumers sharing expertise in novel research partnerships

Co-production of health services research is an increasingly important methodological feature in mental health sector, involving service users/consumers throughout a research enterprise. Consumers and carers are often consulted in processes such as research ethics and clinical governance. Going beyond consultation, co-production can involve joining earlier and more comprehensively with consumers and carers as active researchers, across research project elements from design to publishing.

This paper probes several worked examples of co-produced research, based at University of Melbourne, to examine the emerging ethical issues, roles and practices. Research aims have been: to pose and answer evaluation research questions of interest to consumers, to amplify consumer voice, to juxtapose consumer and clinician perspectives or to generate conversations between perspectives. Co-production research teams have included: a consumer academic, clinician academics, government-employed consumer consultants, local service users as sessional workers, consumer interviewers, mental health workers, managers, social scientists/ linguists. In each case, the majority of team members were people with expertise as consumers of mental health services. Co-work has included grant seeking, project steering groups, thematic and narrative analysis teams, research mentor/mentee couples and writing teams.

Engaging in co-production has implications for research conduct. Taking added time, needing to tease out assumptions, exploring and negotiating language, exercising tolerance and compromise, are common features of co-produced projects. Our studies have informed postgraduate teaching, changes to models of care and grown research capacity among partners. In light of these examples, we consider what kinds of questions may be best answered in a co-production research program.

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Using role-play based learning to teach undergraduate psychiatry

The paper describes an innovative approach to teaching psychiatry to medical students at three clinical schools of the University of Melbourne. In response to poor attendance and student satisfaction ratings the existing Problem-based Learning (PBL) format was replaced with Role-play Based Learning (RBL) modules where the students perform the roles of junior doctor and patients, carers and/or allied health professionals respectively. The aim of the intervention was to provide an interactive learning format that engaged students and promoted clinical knowledge and communication skills in a structured, reflective environment.

RBL draws upon the experiential method of learning, involving the four domains of watching, feeling, thinking, and doing (Kolb & Fry, 1975) and is well suited to teaching important communication skills for psychiatry (e.g., history-taking, communicating with patients, families, carers and other health professionals and conflict resolution). However, while role-play is widely used for assessment purposes, there are few examples of its use in teaching undergraduate psychiatry (Heru, 2011).

After providing an overview of the RBL modules, including sample scripts, the paper will present the results of a formal evaluation of the intervention. Evaluation questionnaires were administered to approximately 130 students from the three participating clinical schools. Data were quantitative (satisfaction ratings) and qualitative (comments). Descriptive statistics were used for the quantitative data and thematic content analysis was used for the qualitative data.

The authors believe that this RBL tutorial program is unique and flexible and could readily be adapted to other teaching hospitals and specialty rotations.

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Communicating risk and uncertainty: Obtaining consent for life saving but non restorative decompressive surgery

Background: For patients with severe traumatic brain injury a decompressive craniectomy (temporary removal of a large segment of the skull) can be a lifesaving intervention however many patients survive with severe neurocognitive disability. The aim of this study was to determine whether an objective assessment of outcome would influence opinion regarding consent for surgery.[1]

Method: Participants were initially shown three cases of severe traumatic brain injury in which decompressive surgery was being considered because the intracranial pressure was rising precipitously despite maximal medical management. A visual analogue scale was used to assess strength of opinion regarding consent for surgery the participants themselves were the injured party. They were then shown long term outcome data in which patient outcomes had been stratified according to injury severity using a mathematical prediction model.[2] They were then asked to reconsider their responses.

Results: Five hundred healthcare workers with a wide variety of clinical backgrounds participated. The responses reflected strongly that the use of an objective assessment of outcome can significantly influence opinion regarding consent for surgical intervention especially when the most likely outcome if the patient survives is severe neurological disability. These attitudes were consistent across different specialties, amount of experience in caring for similar patients, religious backgrounds, and positions in the specialty of the participants.[3]

Conclusions: Access to objective information on the risk of survival with severe neurological disability significantly influenced opinion and this raises important ethical issues that need to be considered when discussing consent with surrogate decision makers.[4]

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Accounting for patient safety through multiple accountabilities

Background: In the field of patient safety, accountability is conceived primarily in formal terms - through the proliferation of guidelines, documentation and reporting requirements. These approaches are popular but controversial, and a focus of patient safety research has been to identify and overcome local barriers to their implementation. When we look at accountability in practice however, we see that accountability is also found in informal and everyday talk and behaviour. Further, the problems of implementation described above can be reframed as tensions between multiple accountabilities.

Methods: This paper draws on a three-year ethnographic study exploring how clinicians practice patient safety. I observed a multidisciplinary group of 72 clinicians in a NSW metropolitan hospital in the course of their daily work, and collected data through written field notes, interviews, documentary evidence and feedback sessions with participants.

Findings: I describe the theoretical and empirical journey of re-thinking accountability, from an initial heuristic duality of formal and informal accountabilities, to a more complex entanglement of both. I show how clinicians inevitably produce accounts that are partial and 'incomplete', at risk of becoming problematically disembedded from complexity. I also show how clinicians are re-embedding these partial accounts, by engaging in accountability practices that foreground multiplicity, diversity and reciprocity.

Implications: This paper argues for a reconceptualisation of accountability that engages with the messiness and complexity of health care practices, in order to gain more traction with the complex and interdependent work practices in health care delivery.

Lars-Christer Hydén & Elin Nilsson

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Couples with dementia positioning themselves as a 'we'

Background: There is little research about how couples themselves define the relationship and how they use their relationship in order to (re-)define their identity when one of them develops dementia. The aim of this paper is to look closer at how couples that live with dementia jointly talk about their relationship.

Methods & Material: Analysis of 11 video recorded joint interviews with couples. The couples were asked to tell about when they met, the experience of dementia and their everyday life. Analysis with a focus on the various ways the spouses positioned themselves as a "we" in the interviews.

Findings: It was found that the spouses frequently position themselves as part of a "we" in the interview. This "we" has a number of functions. First, the "we" may refer to the two spouses. Second, "we" can be used to indicate a collective subject, the couple, being something more than the sum of the spouses. This "we" seems to be especially important facing the changes and challenges brought about by the dementia disease, hence indicating the possibility (and importance) of facing this challenge jointly. Third, "we" is sometimes used in order to establish an identity as a couple especially in relation to shared memories.

Implications: By describing the various ways couples with dementia position themselves as a "we", the individual spouses can be seen as collaborative agents engaged in sustaining their couplehood, rather than just as carer and cared-for joined in a caring relationship.

Margareta Hydén

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The teller-focused interview: Interviewing as a relational practice

Background: This paper traces its origin to 25 years of interview studies of men's violence towards women. Encouraged by Mishler's groundbreaking work on interviewing and argument that we as human beings are storytellers by nature, for my first study I equipped myself with just a few open questions and prepared myself to listen to stories. I learned the hard way that the emic knowledge of a complex and sensitive phenomenon as domestic violence is not gained solely by inhabiting a certain state of mind that honors the interviewee's perspective.

Methods: Major methodological and ethical concerns throughout hundreds of interviews have involved finding ways to facilitate and support the research participants in formulating themselves in as genuine and multifaceted a narrative as possible.

Findings: Over the years the approach "the teller-focused interview" has emerged, with its theoretical and methodological base in feminist research, narrative theory and methodology, and a dialectal way of thinking about the relationship between interviewer and interviewee.

Implications: It is argued that the methodological and ethical concerns brought up are not limited to the area of violence towards women but are also applicable in studies of various types of human experience that are complex, sensitive, and difficult to bring up, such as illness. Indications for the use of the approach will be addressed, and basic aspects of the relational practice of teller-focused interviewing will be presented. Some remarks on the relationship between qualitative research and psychotherapy will also be included.

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Students' participation and introspection in interdisciplinary PBL tutorial: Implications for interprofessional education

Background and objective: In order to develop interprofessional education, Gifu University is conducting a collaborative research with four medical schools and one health care centre. This paper reports students' participation in interdisciplinary PBL tutorials which are implemented at one of the collaborating institutions (Showa University). Interdisciplinary PBL provides opportunities to develop the necessary skills to work with different professionals in a collaborative manner, such as teamwork and communication skills. The purpose of this study is to understand the nature of students' transformative learning in the tutorials by exploring the group dynamics and introspection on their learning.

Methods: Three multidisciplinary cohorts (n=26 third-year students) participated in this research. The processes of collective knowledge construction in the reporting phase of PBL tutorial were video-recorded. The frameworks of discourse structure and speech function were used for analysis of group interaction. Moreover, students' introspection on their participation was examined through the analysis of their learning portfolio.

Findings: This qualitative study identified two different patterns of knowledge construction in three groups: co-constructions among the different professionals and elaborations between the same professionals. Analysis of portfolio indicated that different interaction patterns among three groups were mediated by students' professional identity, understanding of other professionals and perceptions of collaborative learning.

Implications: This study suggests that their participation, identity and perception of pedagogical context are mutually constitutive in their learning. Interdisciplinary PBL has the potential of enhancing students'

collaborative learning (working) skills, but it needs to be noted that their participation is situated in a particular cultural context.

Miho Iwakuma

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Understanding disability from a communication perspective:
A qualitative analysis

An adjustment to a severe disability is accompanied by significant changes in several dimensions—psychological (lowered self-esteem), physical (restricted mobility), and social (changed social identity, the epithet "disabled").   Such sudden changes also require short-term (physical) and long-term (psychological and social) adjustments. In other words, the investigation of adjustment to a disability gives social scientists a unique opportunity to study various facets of human adjustment strategies and processes.

This research details what it means to be "disabled" in today's Japan and how the participants took the journey of disability adjustment. The study also attempts to uncover the wealth of information about what is happening in mundane interactions of PWDs, what method(s) these people use to present themselves, and how they adjust to their disabilities.

A phenomenological method was used mainly for the interview data, whereas an ethnographic method was used primarily for the participant observation and the observation data.

All participants in the present study were PWDs who were once nondisabled and had become people with disabilities (PWDs) after adolescence.

Despite diversity among the participants, having a disability has shaped the course of their relationships with others, their worldviews, and their social positions. This fact also alludes to the point that the impact of their impairments goes far beyond the physical aspects; disability adjustments are also necessary in psychological, interpersonal, and social dimensions. From my analysis, I suggest that more research from a communication perspective pertaining to PWDs should be conducted in addition to research in paramedical fields.

Mahtab Janfada

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Employing an 'integrated, dialogic' approach to medical English education in Iran: Toward a clinical pedagogy

The challenges associated with gaining mastery in academic English are highlighted in particular disciplines in non-native educational contexts. In Iran, this is evident in medicine and the current pedagogy adopted by medical faculties which involves a non-dialogic delivery of knowledge. Students are not given opportunities to internalize, contextualize and conceptualize academic and professional medical knowledge in English. Importantly, they remain voiceless outsiders, who are neither sufficiently competent nor confident to operate in the global medical community.

To address this issue, an innovative pedagogical approach to medical English was designed which is informed by socio-cultural theories of learning and language (Vygotsky, 1986; Bakhtin 1981). This multi-layered dialogic approach to English language learning was aimed to integrate and balance critical and pragmatic literacy (Harwood and Hadley, 2004) and academic and professional medical discourses, and to address the various 'needs and rights' (Benesch, 1999) of a group of Iranian medical students. It is applied through various meditational tools (Wertsch, 1991) such as role-plays, clinical scenarios, narrative and evidenced-based medical texts, and doctors' circle sessions.

Findings revealed that 'Integrated, Dialogic' approach could scaffold medical students' understanding of their academic/professional identity; make them aware of different discoursal features in the discipline of medicine and the extent and depth to which they can appropriate this understanding toward meaningful clinical communication.

This in turn provides insightful implications for future practices and particularly to establish and strengthen a Clinical Pedagogy where students' understanding occurs beyond methodological level and leads

to deeper layers of ontological and epistemological transformations as potential professionals.

Rodney H. Jones

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Knowledge construction and expertise in online discussions of genetics

Background and objectives: Today more and more people are interacting with complex medical information without the benefit of professional advice. One example of this can be seen in the proliferation of direct-to-consumer genetic testing services offered by companies such as 23andMe and DeCodeMe. This paper analyzes how customers of such services use online forums to share information and advice, engage in joint problem solving, and collaboratively construct knowledge about genetics.

Data and methods: The data come from a corpus of customers' postings from the public forums of the website for 23andMe. Using tools from mediated discourse analysis, it examines the linguistic strategies participants use to defend and contest scientific claims, manage identities and relationships, and represent the voices of 'experts' like scientists and doctors, as well as 'non-experts' friends and family members.

Findings: Results of the analysis show that while participants are often able to reproduce the patterns of reasoning and evidentiary practices of biomedicine, they often use these practices to challenge mainstream medical consensus and assert a kind of 'expertise of non-expertise' which privileges personal experience and 'genetic identity' over the discourse of biomedicine.

Implications: This paper makes a contribution to understanding how laypeople appropriate medical information from the internet and other media, from professionals, and from friends and family members, and how they work together with other laypeople to evaluate and make sense of this information and apply it to specific health problems.

Iréne Josephson

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In what ways do physiotherapists utilize patient resources in intervention? A qualitative analysis of the interaction in the context of non-specific low back pain

This paper reports on an empirical study of how patient resources are explicitly utilized in intervention. A qualitative analysis of five video-recorded and observed first encounters between patients with non-specific low back pain (NSLBP) and physiotherapists in primary care was conducted in southern Sweden. The analysis focuses on physiotherapists' various ways of explicitly utilizing patient resources in intervention. The findings illuminate a gap between the number of occurring patient resources and the explicit utilization of these resources in intervention. Resources like objects, condition, personal characteristics and energies were identified and followed during the first encounter with physiotherapists. These resources were checked by the therapists or initiated by the patients. Resources concerning personal characteristics (such as optimism and motivation) and energies (such as experience-based knowledge) seem to be the underutilized. The findings raise questions about professional challenges beyond professional skill, indicating a need for clinical improvement regarding interaction, with potential implication for back pain recovery. The findings are discussed in relation to patient participation and professional ethics.

Grace Khunou

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Masculine identity and access to health: Perceptions and experiences of private and public health services

Background: Although much research on men and health tends to suggest that men don't care about their health, resent studies indicates that hegemonic masculine traits might have health positive impacts on men. In South Africa men's specific health programs are virtually non-existent so is policy considerations for men's general need for health care Again given the persisting social and economic inequalities how and when men access health is further impacted. Thus arguing that, men's ideas of what it means to be a man is the only factor that influences the health practices is erroneous.

Methods: The qualitative data derived from twenty interviews with men from Gauteng and Limpopo was analyzed using thematic content analysis.

Findings: This paper provides a lens into how men's access to health is encouraged or deterred by service delivery challenges in the public health sector and again how the private health sector might be economically inaccessible to them. However, varied ideas of what it means to be a man held by the participants influenced their identities and thus how the socio-economic factors impacted their access to health.

Implications and Conclusion: In conclusion the paper argues that men's health practices are complex and should be understood as such for health policies to effectively address their health needs.

Henry Kilham

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Increasing deliberate ethics consideration in paediatrics

Every day, clinicians make mostly good decisions in patient care without consciously recognising that these decisions have involved ethical judgments. The untested proposal to be presented is that even momentary conscious focusing on ethics in treatment situations should lead to better treatment.

Modern clinical care involves ever-increasing governance and risk management, hence increasing rules and guidelines. This may lead to a more mechanistic and less thoughtful approach to treatment. Increasing attention is being given to concepts such as 'patient-centred' health care. In paediatrics this is complicated by needing to treat the child in the context of the family, where the best interests of the child usually but not always coincide with those of the family.

Deliberate examination of a clinical ethics dilemma has for some been reduced to applying the four principles of Beauchamp and Childress (beneficence, non-maleficence, autonomy and justice). These principles are too cumbersome for everyday decision-making, yet totally inadequate for more serious ethical dilemmas, which Beauchamp and Childress themselves say 'blend appeals to principles, rules, rights, virtues, passions, analogies, paradigms, narratives, and parables'.

The deliberate and invariable interposition of a 'test question' is suggested, whenever any investigation or intervention is being instituted: 'is this test or treatment in the best interests of the child/what could it achieve/what harm could it do'. While it is recognised that clinicians usually consider the best interests of the child, the difference here is that ethics is at least briefly made the focus of attention, to be quickly dismissed if all seems right, and to be taken further if not. The discussion will look at merits, practicality and further evaluation.

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Health Møre og Romsdal Trust, Norway[1]; Aalesund University College, Aalesund, Norway[2]; Norwegian University of Science and Technology (NTNU), Trondheim, Norway[3]

Intensive care unit nurses' perceptions of patient participation in the acute phase of chronic obstructive pulmonary disease exacerbation

Aim: To explore intensive care unit nurses' perception of patient participation in the acute phase of obstructive pulmonary disease exacerbation

Background: An acute exacerbation is a life-threathening situation, which patients often consider to be extremely frightening. Healthcare personnel exercise considerable power in this situation, which challenges general professional notions of patient participation.

Design: Critical discourse analysis.

Methods: In the autumn of 2009, three focus group interviews with experienced intensive care nurses were conducted at two hospitals in western Norway. Two groups had 6 participants each, and one group had 5 (N = 17). The transcribed interviews were analysed by means of critical discourse.

Findings: The intensive care nurses expressed that an exacerbation is often an extreme situation in which healthcare personnel are exercising a high degree of control and power over patients. Patient participation during exacerbation often takes the form of non-involvement. The participating nurses attached great importance to taking a sensitive approach when meeting patients. The nurses experienced challenging ethical dilemmas.

Conclusion: This study shows that patient participation should not be understood in universal terms but rather in relation to a specific setting and the interactions that occur in this setting. Healthcare personnel must develop skill, understanding and competence to meet these challenging ethical dilemmas. A collaborative inter-professional approach between

physicians and nurses is needed to meet the patients' demand for involvement.

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Narratives of breathlessness in chronic obstructive pulmonary disease

Aims and objectives: This is a study conducted to explore patient perceptions of chronic obstructive pulmonary disease exacerbation and the patients' experiences of their relations with health personnel during care and treatment.

Background: Patients suffering from acute exacerbation of chronic obstructive pulmonary disease often experience life-threatening situations and undergo non-invasive positive pressure ventilation via bi-level positive airway pressure in a hospital setting. Theory on trust, which often overlaps with the issue of power, can shed light on patient experiences during an acute exacerbation.

Design: Narrative research design was chosen.

Methods: Ten in-depth qualitative interviews (N = 10) were conducted with patients who had been admitted to two intensive care units in western Norway during the autumn of 2009 and the spring of 2010. Narrative analysis and theories on trust and power were used to analyse the interviews.

Results: Because of their breathlessness, the patients perceived that they were completely dependent on others during the acute phase. Some stated that they had experienced an altered perception of reality and had not understood how serious their situation was. Although the patients trusted the health personnel in helping them breathe, they also told stories about care deficiencies and situations in which they felt neglected.

Conclusion: This study shows that patients with an acute exacerbation of chronic obstructive pulmonary disease often feel wholly dependent on health personnel during the exacerbation and, as a result, experience extreme vulnerability.

Relevance to clinical practice: The findings give nurses insight into building trust and a good relationship between patient and caregiver during an acute exacerbation of chronic obstructive lung disease.

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Discussion of age and age related issues in cancer multidisciplinary meetings

Background: Cancer multidisciplinary meetings (MDMs), attended by medical and allied health staff, are a forum where the medical management of people with cancer is discussed. For older people factors such as medical comorbidities, physical function and social situation impact on treatment tolerance. However, these factors may not be routinely considered in cancer MDMs.

Aims: To investigate whether age and age related factors are discussed in cancer MDMs and to examine the terminology used to describe these factors.

Methods: Twenty cancer MDMs were attended. Phrases describing age and age related factors were hand recorded for people aged over 69 discussed. Frequency of discussion of these factors was reviewed using descriptive statistics. The terminology used was explored using a thematic analysis.

Findings: Data were collected for 68 people aged over 69. Whilst age (82%) and comorbidities (56%) were usually described, social situation (17%) and physical function (10%) were infrequently mentioned. For 40% of older people general descriptors were used.

The most common general descriptors were 'fit', 'well' and 'good'. 'Fit' was both a general descriptor and used in the phrase 'fit for treatment'. General descriptors were often accompanied by adverbs including 'very', 'pretty' and 'quite'.

Implications: In addition to age and comorbidities, general descriptors of older people were common, these potentially influence decisions reached. These descriptors were not objective and associated adverbs were potentially ambiguous. However, their use indicates awareness that factors other than comorbidities and age are important to decision-

making, suggesting introduction of more objective language or instruments may be useful.

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Victoria University[1]; University of Melbourne[2]

Use of real stories in cultural sensitivity simulations with simulated patients: necessity or invasion of privacy?

Issue explored: Simulated patients (SPs) are people trained to portray patients for the purpose of health professional education. SPs play roles based on real stories to ensure authentic learning experiences. However, emphasizing cultural issues to teach culturally sensitive communication often gives rise to cultural stereotyping and stigmatising. Static definitions of culture risk homogenizing ethnic and cultural groups.

 This presentation explores the use of intersectionality as a theoretical framework to address the complexity of multiple embodied cultural and social relations that impact disparately on population health.

Methods: Culturally diverse people were recruited to be trained as SPs as part of a HWA funded Cultural Respect Encompassing Simulation Training (CREST) project. Composite simulated patient scripts were co-created with the SPs during their training to enable them to insert their own culturally-derived context, within a multi-dimensional fictional role.

Findings: Individual deviations provided by each SP enabled variation to the role allowing them to display the true richness, complexity and cultural variation inherent in the population. These variations within a structured scenario removed the individual's personal history sufficiently to protect the SP from undue exposure of private information and potentially distressing re-enactments.

Implications: The theory of intersectionality provided a useful framework for the training of SPs to play authentic roles. The SPs addressed student learning outcomes in the simulation and used the framework of the case study to establish context. This approach could facilitate authenticity and safety in other simulations outside of the cultural perspective such as stigmatised illnesses or disability.

Jenni Livingston

University of Melbourne

Parent preferences about the ways information is provided to them for perinatal autopsy consent

Background and objective of the paper: People providing informed consent in medical contexts need information for informed consent requirements to be satisfied. There are few empirical studies about information provision preferences in informed consent. This is despite the abundant literature on patients' preferences for their involvement in medical decision-making, for example. In practice, clinicians have been encouraged to build understanding in patients by gradually "feeding out" information to avoid "overload". This paper examines gradualism in information provision as parents recall their experiences providing informed consent to the autopsy of their baby.

Methods: Recently bereaved parents who provided informed consent to autopsy following a perinatal death in a tertiary hospital were asked about their experiences and understandings of the tragic birth and the informed consent process. Grounded theory informed the analysis of the 26 semi-structured interviews of 12 couples and 14 mothers.

Findings: Gradual delivery of information about autopsy often builds frustration and compounds the sense of powerlessness parents experience when their baby dies. Problems associated with gradual delivery are explored in terms of potential harms to parents in this context. The distinction between the tailoring of information and the tailoring of the information context is discussed and an alternative approach to information provision that deals with these concerns is offered for debate.

Implications: These empirical findings challenge accepted practice in the provision of information in informed consent and perhaps any context in which information is provided to patients.

Rosalind McDougall[1] & Lynn Gillam[2]

University of Melbourne[1]; Royal Children's Hospital, Victoria, Australia[2]

Clinicians' "decisions" versus parents' "wishes": ethical implications in conflict situations

When discussing children's medical treatment, it is standard to refer to clinicians making "decisions" or "judgments" and parents having "wishes". This is the case both in hospital settings and in ethics literature. This paper argues that this type of language has problematic ethical implications, particularly in situations where conflict arises between health professionals and parents about the most appropriate course of treatment for a child. It implicitly privileges the clinicians' views, failing to value the expertise on which parents are drawing. I suggest that parents' views, like clinicians', should generally be accorded the status of "judgments". Clinicians' views are respected as judgments because they are based on substantial medical expertise and a set of core ethical values relating to their professional role. I will suggest that parents too are in a position to base their decisions on their expertise and an ethical standpoint. Parents' are widely recognized as the experts on the non-medical aspects of their children's lives and there is increasing empirical evidence to suggest that "being a good parent" is a motivating value when parents are making medical decisions for their child.

Elizabeth Manias[1]; Sharon Kinney[1,2]; Noel Cranswick[1,2] & Allison Williams[3]

The University of Melbourne[1]; Royal Children's Hospital, Victoria, Australia[2]; Monash University, Australia [3]

Effects of interprofessional communication problems on medication errors in hospitalised children

Background and objective: Children are particularly susceptible to experiencing medication errors. This study explored the characteristics of reported medication errors occurring among children in an Australian children's hospital, with particular emphasis on how problems with interprofessional communication contributed to these errors.

Methods: A retrospective clinical audit was undertaken of medication errors reported to an on-line incident facility at an Australian children's hospital over a four-year period.

Findings: A total of 2,753 medication errors were reported over the four-year period, with an overall medication error rate of 0.31% per combined admission and presentation, or 6.58 medication errors per 1000 bed days. All reported medication errors were caused by some kind of communication problem in some way: the most common involved misreading or not reading medication orders (n=804, 29.2%). Problems with bedside communication (n=739; 26.8%) and handover (n=568, 20.6%) were other common causes. In considering the key contributing factors associated with medication errors, communication relating to patient movements across different health care settings was the most common (n=929, 33.7%). Other common contributing factors related to frequent interruptions and distractions (n=543, 19.7%), and insufficient or incorrect counselling provided to children and parents (n=219, 8.0%).

Implications: Greater attention needs to be played by health professionals in how they verbally communicate with each other about medications. Specific dedicated time for collaboration between health professionals in addressing medication management issues can assist in avoiding medication errors. Health professionals situated across different

health care settings require greater diligence in providing information about medications during children's ward transfers.

Tim McNamara, Sally O'Hagan & John Pill

University of Melbourne

Extending the scope of speaking assessment criteria in a specific-purpose language test for migrating health professionals

Background and objective: This paper considers challenges of reconceptualising "language" in the speaking sub-test of the Occupational English Test, a specific-purpose language test for overseas-trained health professionals seeking registration to practise in Australia. Current assessment criteria are applied by trained language professionals without any particular knowledge of the healthcare context. Health professionals' views on what is required for effective health professional–patient interaction have informed revision of these assessment criteria intended to make them more relevant to the working situation.

Methods: Aspects of performance amenable to inclusion in an expanded test construct were drawn from thematic analysis of health professional educators' commentary on trainee interaction with patients. A checklist of examples from the commentary dataset was developed as an intermediate step in formulating new criteria, which included Clinician engagement and Management of interaction. Seven language assessors were trained in applying the draft criteria and a pilot assessment of 300 test performances (role-plays) was undertaken. Statistical analyses of the assessors' scores were studied along with assessors' feedback on the training and the new criteria.

Findings: While reporting some initial difficulty in orienting to the new criteria, assessors can recognise them in test performances and score them consistently.

Implications: With appropriate training, language assessors can act as proxies for health professionals in the assessment of language-related aspects of performance valued by educators in the health professional–patient consultation. The new criteria appear suitable for inclusion in an expanded specific-purpose language assessment tool, which thus better reflects language demands of the healthcare context.

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Pharmacist-patient medication communication on patients' hospital admission and discharge

Background: Safe medication management during and after a patient's hospital stay requires effective pharmacist-patient communication. This paper examines the sociocultural and environmental influences shaping pharmacists' medication communication with patients on admission and discharge, the actual communication interactions and outcomes of these encounters.

Methods: This ethnographic study draws on 41 semi-structured interviews with healthcare professionals (nurses, doctors and pharmacists), patients and family members in five specialty settings of a hospital, and 90 hours of participant observation of healthcare professionals in two of these settings. All observations and interviews were audio recorded and transcribed verbatim. A thematic analysis was performed.

Findings: Key sociocultural and environmental influences on pharmacist-patient interactions on admission and discharge included pharmacists' professional experience and specialist medication knowledge, and doctors' accuracy in documenting patients' medications. Patient factors involved their English language competence, medication knowledge and physical state. The timing and place of communication were important organisational influences.

Medication history-taking and discharge counselling involved pharmacists questioning and informing patients. Additional information was sometimes sought by ringing community pharmacists, general practitioners and consulting carers. Pharmacists almost always needed to interact with doctors to review patients' prescribed medications. Communication encounters with patients were subsequently often lengthy and repeated, and were frequently interrupted. Outcomes of these complex communication encounters included delayed patient

discharge, and the potential for medication errors, affecting patient safety and quality of care.

Implications: To improve pharmacist-patient medication communication, patients should carry an accurate current medication list. Pharmacists could proactively educate doctors on errors when communicating about patients' prescribed medications.

Munyane Mophosho

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Caregiver problem description in a multilingual and multicultural health care context: Issues and implications for speech-language therapists

Research has shown that patients who don't speak the same language as health care professionals may receive limited health services when compared with people being served by professionals that speak the same language as them, thus potentially leading to poor health outcomes. The purpose of this study was to explore and analyse the interactional characteristics and features of speech-language therapists' and care givers of children with disabilities in two South African urban hospital settings. This poster speaks to data that was collected through a qualitative study using observations, video recordings of interactions between speech-language therapists during initial interviews of caregivers of children with severe disabilities. The data collected was analysed using conversational and thematic content analysis.

Preliminary findings indicated a disjuncture between what the therapists expect and how the clients respond. Lack of knowledge of the do's and don'ts in the client's ways of speaking was also evident. Language and culture issues– the therapists seemed to need to be fore-grounded in the culture of those they help. Furthermore, the clinic setting appeared also to present challenges for people who are used to alternative health practices. In conclusion, the paper argues that, to improve health outcomes in these settings; academic curriculum, policy and clinical practice of speech-language and audiology students and professionals should take into account multi-lingual and multi-cultural context; this will enhance the efficacy of management of communication disorders within this context.

Simon Musgrave, Marisa Cordella, Louisa Willoughby & Julie Bradshaw

Monash University, Australia

Triadic medical interaction with a bilingual doctor

Background and objectives: Immigrants from NESB in Australia are well served by interpreter services but there is concern amongst older-established migrant groups about the efficacy of such services for their older members. On occasion bilingual patients may encounter doctors who share their background language and such consultations provide a valuable comparison to identify communication problems specific to interpreted consultations.

Methods: Data for this paper is drawn from a wider study of bilingual consultations with older patients in Melbourne. In the data analysed here the specialist neurologist at an outpatient clinic is an Italian-English bilingual and an interpreter was not present. We use discourse analysis to explore how the participants draw on their linguistic resources, and we examine the role of the accompanying family member (FM) engaging with both patient and doctor.

Findings: The absence of an interpreter allows more direct communication with the older, Italian speaking patient, and her accompanying FM, as both have some knowledge of both languages. Our analysis shows that the FM 's roles include supporting, challenging and co-constructing the patient's account. Different linguistic resources are used to achieve these ends, with English used mainly between the doctor and the FM.

Implications: Data from other consultations has shown us that contributions in Italian by FMs are not consistently translated by an interpreter (Bradshaw et al, to appear). Together with the current results, this suggests that management of the three-way communication which includes a FM should be given more attention in the training of both medical practitioners and interpreters.

Bradshaw, Julie, Marisa Cordella, Simon Musgrave and Louisa Willoughby. "Being heard: Contested meanings in multiparty medical consultations." To appear in *Intersections: Applied Linguistics as a Meeting Place*, ed. E.Stracke, Cambridge Scholars Press.

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Health literacy and empowerment in the context of patients' emergency department use

Background and objective: Although many studies have shown the importance of health literacy in predicting patients' health behavior in very different contexts, little is known about whether limited health literacy (HL) and patient empowerment (PE) explain patient's over and underuse of emergency departments(ED). The few studies that had been conducted so far show that limited HL is associated with greater emergency department use(AHRQ, 2011), and the prevalence reported of limited HL in ED patients is approximately 25% (Ginde, 2008). Based on Schulz & Nakamoto's Extended Health Empowerment Model (2012), the paper will report results from a survey among patients in four ED in a large city of Northern Italy. In particular, we studied the role of health literacy, empowerment and potential confounding variables that might influence patients' choice to present themselves at an ED. We hypothesized – following the Extended Health Empowerment Model – that health literacy and patient empowerment are two distinct but closely interwoven concepts, and that considering both in conjunction could explain patients' ED visits better than health literacy alone.

Methods and Findings: We conducted a cross-sectional study to assess the level of HL and PE in ED patients in Milan (n=313). Eligible participants were aged >18 years, auto-presented, with white and green triage code. The triage code determines the priority to be visited by medical staff. White and green codes designate not urgent cases that could be treated equally by general practitioners and thus are considered as improper access. We collected data regarding the level of HL, PE, and other variables. A follow-up telephone survey (2 months after) was conducted, inquiring patients' behaviour after their visit to the ED and patients' risk perception.

Implications: In our paper we will present particularly data regarding the question whether health literacy and empowerment explain unnecessary visits to ED.

Andrea Paul

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Discourse, communication and the PR examination: a cross-disciplinary approach to procedural skills teaching

Background: Internal and sensitive examinations require complex communication tasks prior to and during examination. Competencies in the Australian Curriculum Framework for Junior Doctors (2006) include 'understand the principles of 'good' communication, e.g. active listening' or 'communicate with patients and carers in ways they understand' or 'show empathy'. There is little data on how these goals are unpacked or ways the linguistic intercultural and pragmatic competencies required for these skills can be taught.

Conceptualising clinical communication in terms of specific tasks, linguistic features and pragmatic competencies facilitates an explicit approach to clinical communication skills teaching and assessment. It has evident high face validity for learners, and is effective for internationalised undergraduate and overseas-trained clinician cohorts working with similarly diverse patients.

Method: During cross-disciplinary clinical skills training, 72 medical students were recorded practicing a patient interview prior to conducting a rectal examination. Interviews are analysed for communicative function, sequencing, grammar and vocabulary use within utterances, and interactive strategies. Frameworks for analysis and teaching method are drawn from cross-cultural pragmatics (Boxer 2002), systemic functional linguistics & genre theory (Martin & Rose 2003) and discourse analysis. Students evaluated the session.

Findings: Students demonstrate capacity to implement taught strategies; increased confidence providing rationales to patients, explaining procedures, and addressing patient concerns and questions. A sub group required further support. The cross-disciplinary teaching approach was valued.

Implications: These tools currently support clinical practice in medical specialty contexts (e.g. Fine 2006, Slade et al 2009). They can be

similarly applied into mainstream undergraduate and clinical workforce education.

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Communication about diagnostic uncertainty in paediatric genetics: "It's challenging and a bit frustrating"

Background and objectives: Recent advances in genetic technologies provide hope for a diagnosis for many children with developmental delay. However, results generated through use of these technologies have also increased the level of complexity and uncertainty of communication during genetic consultations. We investigated how parents and clinicians respond to uncertainty in Australian paediatric clinical genetic consultations.

Methods: Markers of uncertainty were tracked through 32 audio-recorded consultations, with a particular focus on the explanation of results. Through a detailed linguistic analysis we investigated how interactants dealt with uncertainty, by assessing clinicians' level of epistemic authority and how parents responded to this. We also investigated markers such as dysfluency and the use of contrast. These results were correlated with a thematic analysis of post-consultation parent (n=32) and clinician (n=11) interviews.

Findings: In examining the interactions, clinicians generally spoke with a low level of epistemic authority indicating the high level of uncertainty in results. Clinicians often mitigated this uncertainty using contrast markers and historical narratives to explain the evolution of genetic technology and the potential for more certainty in the future. Interview data indicated most clinicians were frustrated with uncertain test results although some were more comfortable. Parents generally understood what an uncertain result meant for their child but some were disappointed by limitations of the technologies.

Implications: Detailed analysis of three complementary data sources can provide a rigorous and unique set of perspectives on the impact of new

genetic technologies for clinicians and parents. Findings from this study will inform best practice in this area of medical communication.

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Sources and management of interactional troubles in emergency calls

Background and objective: Research on emergency calls has examined a range of interactional troubles that may occur in such calls, including mistrust of the caller by the dispatcher (Imbens-Bailey & McCabe, 2000; Whalen & Zimmerman, 1990), problematic exchanges between callers and dispatchers (Tracy, 1997); what happens when callers become rude (Tracy & Tracy, 1998); and the role of interactional factors in potentially fatal breakdowns in communication between callers and dispatchers (Whalen, Zimmerman & Whalen, 1988). In this paper, we build on this research, examining preliminary findings from a project on interactional troubles in emergency calls in South Africa. The South African context is unique in terms of its linguistic, cultural and socio-economic diversity, and may thus be characterised by unique troubles in emergency call interactions.

Methods: We draw on a range of data sources, including conversation analysis of 77 recorded calls to a government ambulance service call centre, interviews and focus groups with the call centre employees, and ethnographic observations of the call centre.

Findings :Preliminary analyses of the data have revealed a number of potential sources of interactional troubles, and practices for managing them, including practices for giving and receiving information (e.g., telephone numbers, addresses, and descriptions of the nature of the emergency), relationships between callers and operators (e.g., mismatches in language, expectations, competencies), and the role of institutional arrangements in the interactions (e.g., relationships between the call centre and hospitals) .

Implications: Potential implications of the findings for understanding interactions in emergency calls, and for improving the quality of emergency services will be discussed.

Jennifer Philip

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Re-thinking the primacy of the patient in the doctor patient consultation

Background: Traditionally, Western medicine places the patient at the centre of care, controlling information and decision-making about his or her illness and its treatment. However, in the setting of advanced illness, family members are increasingly relied upon to provide care and support to the person who is ill. Palliative care explicitly recognises the role of family carers as recipients of care. This paper draws on data emerging from two separate studies in palliative care which highlight the strengths and challenges of a model of consultation which places the seriously ill patient exclusively at the centre of care.

Method: Two separate qualitative studies were undertaken exploring the experiences of illness and the supportive and palliative care needs according to patients with chronic obstructive pulmonary disease and malignant glioma, and their carers. Semi-structured interviews were undertaken with consecutive patients and their carers attending for health care at an acute hospital. Interviews were recorded, transcribed, and subject to thematic analysis.

Results: An important theme emerging in both studies was the dynamics of the clinical consultation and the roles of the patient and the family member or carer, particularly as the patient's illness progressed. The family carer had frequently taken on many tasks, including both onerous and intimate tasks of caring, and this had made a substantial impact upon the carer's life. When the patient was very ill and particularly in the setting of cognitive impairment, carers felt responsible for providing medical information, and advocacy. Yet carers reported they seemingly lacked legitimacy and 'voice' in the consultation, with curtailed access to patient information, and involvement in decisionmaking. Some carers noted a tension between advocating for the needs of the patient and for their own needs.

Implications: There is a need to consider the role of family carers in the health care interactions with patients with advanced illness. Carers' views, awareness of patients' needs and indeed their own needs are critical to successful home care and illness management, yet the needs of carers and their involvement in care decisions are frequently not sought. Even in palliative care, the degree to which family members are considered is not formalised and the response in the setting of competing needs remains unclear. The role of family carers in the clinical consultation requires further study in different settings, and alternative models of care provision may be required.

John Pill

University of Melbourne

An exploratory model of what doctors value in the doctor-patient consultation

Background and objective: Study of medical educators' feedback on trainees' interactions with patients can clarify what the medical profession values, since the educators aim to acculturate trainees to professional expectations and behaviours. Such an investigation of indigenous assessment practices (Jacoby & McNamara, 1999) was done to inform a possible broadening of the scope of assessment in the speaking component of an English-for-specific-purposes test taken by migrating doctors seeking registration to practise in Australia, responding to concern that the test was not engaging sufficiently with aspects of performance candidates need to demonstrate for effective communication with patients.

Methods: Educators' feedback on trainee performance came from two contexts: a) two workshops in which videoed interactions between doctors from non-English-speaking backgrounds (NESB) and simulated patients were shown to educators (n=13) who provided oral commentary, and b) 92 reports written by educators (n=25) after observing general practice trainees (ESB and NESB) with patients in routine clinics. A thematic analysis of the data was undertaken.

Findings: Analysis revealed aspects of performance the educators valued and their inter-relationships. A model representing this conception of doctor-patient interaction was developed, comprising three main elements: foundation, performance and goals of the consultation.

Implications: In addition to the revision of assessment criteria in a test of spoken English, the greater understanding afforded by this model of what doctors value in the consultation can inform clinical communication skills training generally, as well as the orientation and acculturation to professional practice for trainee doctors, regardless of place of training or first language.

Jacoby, S., & McNamara, T. (1999). Locating competence. *English for Specific Purposes*, 18(3), 213-241.

Liz Pryor, Robyn Woodward-Kron & Stuart Marshall

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Co-constructing safe patient care: the challenges of intercultural, intra-professional telephone communication

Background: Most studies of the communication skills of International Medical Graduates (IMGs) focus on doctor-patient interactions; few have examined intra-professional i.e. doctor to doctor discourse. Furthermore, intra-professional interactions are frequently done by telephone and are central to managing patient-care issues, particularly in the context of junior doctors consulting senior doctors for advice and assistance. This study examined the effectiveness of telephone calls from junior IMG doctors to a senior doctor in the context of simulation training using a communication protocol (ISBAR).

Methods: This exploratory study used genre analysis of audio-recorded junior IMG to senior doctor telephone patient consultations and retrospective verbal reports from the senior doctor involved in the call. Twelve telephone consultations made to a senior doctor during the simulation training were recorded. Feedback comments on these calls from the senior doctor were transcribed and analysed thematically; these results informed the development of an analytical tool to examine the structure and content of the junior IMG doctors' calls and the effectiveness of the calls from the senior doctor's perspective.

Findings: Insights from the senior doctor highlight the many institutional, professional and situational variables contributing to effective calls. A generic structure of 9 stages was identified for the effective calls. In less effective calls, although most stages were jointly achieved, analysis revealed difficulties with sequencing, realisation and interactional management with shifts from workplace to apprenticeship styles of discourse.

Implications: Findings have implications for IMG communication skills training, and more broadly for considerations of the interactional dimension of communication protocols such as ISBAR.

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Effective healthcare communication in Hong Kong emergency departments

Background: Effective communication has long been recognised as fundamental to the delivery of quality health care. This research analyses spoken interactions between doctors, nurses and patients in one ED in Hong Kong, identifying features of the actual language used in the consultations. It aims to address the challenges and critical incidents caused by breakdowns in the communication and identify ways in which staff can enhance their communicative practices.

Methods: The research used a mixed methods, combining qualitative ethnographic approach, quantitative analysis of survey data and discourse analysis of audio-recorded interactions. It consisted of 28 interviews with clinicians, a questionnaire completed by all ED staff and 10 patients recorded from triage to disposition. We focus on the thematic analysis of the interviews using NVIVO and a quantitative analysis of the survey data. By identifying the recurring factors that affect communication, we explore the connection between these factors and the contextual factors of the ED and the communication patterns between clinicians and healthcare professionals.

Findings: The findings outline the major challenges to effective communication: the absence of information about the processes in the ED, the pressure of time and the lack of manpower, divergent goals of doctors and patients, the way diagnoses and treatment plans are delivered and the consequent lack of compliance with these plans, and how professional roles and hierarchy impact on patient experiences.

Implications: We believe the research in Hong Kong will provide a model for future research on the relationship between communication, patient safety and the patient experience.

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Restoring core values: The International Charter for Human Values in healthcare

Background: Values are fundamental to practicing compassionate, ethical, and safe relationship-centered healthcare. Attending to these improves health outcomes, quality of care, and patient/clinician satisfaction, yet these values have not yet received the emphasis necessary to make them central to every healthcare encounter.

Objectives: 1) To describe work to date on the International Charter for Human Values in Healthcare; 2) to discuss translation of the Charter's universal values into education, research, and practice; and 3) to discuss its uses in teaching humanism, compassion and professionalism.

Methods: An international working group of expert educators, clinicians, linguists, and researchers identified initial values that should be present in every healthcare interaction. The working group and four additional groups -- National Academies of Practice (NAP) USA, International Conference on Communication in Healthcare, Interprofessional Patient-Centered Care Conference, American Academy on Communication in Healthcare Forum -- identified values for all healthcare interactions and prioritized top values. The NAP group also prioritized top values for interprofessional interactions. Additional data was gathered via a Delphi process and two focus groups of Harvard Macy Institute scholars and faculty.

Results: Through iterative content analyses and consensus, we identified five categories of core human values that should be present in every healthcare interaction: Capacity for Compassion, Respect for Persons, Commitment to Integrity and Ethical Practice, Commitment to Excellence, and Justice in Healthcare. Through further consensus and Delphi methodology, we identified values within each category.

Implications: The International Charter for Human Values in Healthcare[1] is a cooperative effort to restore core human values to healthcare around the world. Major healthcare and education partners have joined this international effort. We are working to develop methods to translate the Charter's universal values into education (teaching, assessment, curricula), research and practice.

[1] The International Charter for Human Values in Healthcare. http://charterforhealthcarevalues.org.

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Laboratory communication training in five health care professions

Background: Health Care Professionals who are skilled at communicating is a prerequisite for providing welfare services of high quality. Teachers from five Health Care Bachelor programmes at University College North, Denmark have undergone training as facilitators concerning students training communication skills in cooperation with actors. From 2011 to 2012 all five bachelor programmes implemented the use of laboratory training for students training communication skills.

Relevance: The laboratory offers a safe setting for students to practice communication skills and discuss ethical dilemmas.

Aim: To educate health care students to actively involve citizens in decision making concerning health services in an experiential though safe setting.

Participants: Health Care Students from five Professions: Midwifery, Nursery, Occupational Therapy, Physiotherapy, Radiography.

Methods: Communication skills are trained in groups in a laboratory containing a stationary web-camera with a microphone and a projector pointing at a large screen. Students are doing roleplays with an actor playing a patient/citizen. The situation is being recorded. Then students receive feedback from peer students, the actor and the facilitating teacher.

Results: Students emphasize the advantage of trying out different communication approaches in a safe setting close to real life. Furthermore cross professional consciousness on similarities in health communication challenges were identified. This has led to a common awareness of potentials for cross educational cooperation.

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Conclusions: Communication skills training in a laboratory with an actor has been successfully implemented in all five Health Care Bachelor Programmes. Implications for future work will be to further develop student communication training and training programmes for clinical supervisors.

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Simple and honest signals in patient-doctor communication

Background: Several factors influence patient's trust and trust in turn influences the doctor–patient relationship. Current studies are focused on the development of complete models and theories about the role of trust and how it can be maintained and reinforced. In particular, recent literature pointed out the attention on the quality of the personal relationship and its dynamics by analyzing the role of communication and the elements that influenced trust giving in the frame of general practioner (GP) consultations.

Objective: The aim was to analyze several aspects of the interaction between patients and GP in order to understand trust formation and maintenance by focusing on communication channels. The impact of socio-demographic variables in trust relationship was also evaluated.

Method: Individual semi-structured interviews were carried out with 100 patients in six community-based, primary care clinics in Trentino, Italy, Europe.

Findings: Findings revealed that patients trust their GP to a high extent; they do so by relying on simple signals which are based on the quality of the one-to-one communication, as well as on behavioral and relational patterns. Patients infer the ability of their GP by relying more on the so-called social "honest signals" than on content-depending features. Furthermore, socio-demographic variables have an impact on trust, especially in less literate and elderly people. The honest signals models resulted significant in a confirmatory path-analysis model.

Implications: The study can be helpful to both clinicians and researchers. For doctors, it suggests a way of thinking about encounters with patients. For researchers, it underlines the importance to analyze some new key factors around trust for future investigation in medical practice and education.

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How patient identity is actively shaped within diabetes review consultations and the implications for goal-setting, self-management, and key indicator exploration

Background: Patient-centred care is embedded within UK National Health Service policy and the aim in diabetes is to optimise self-management through interactional strategies that include motivational interviewing and individualised goal-setting arrived at through negotiation between clinician and patient. Some evidence suggests poorer awareness of diabetes and its complications in ethnic minority patients and the tackling of fewer of the key indicators of disease progression at annual diabetes review.

Methods: We analysed the sequential nature of talk of 48 nurse-led video- and audio-recorded diabetes consultations in inner London primary care settings. Instances where patients accounted for the success or failure of weight loss or diet self-management are considered here.

Findings: The legitimacy nurses gave to patient's accounts varied depending not only on whether they had gained or lost weight or eaten appropriately or not, but whether or not this was a continuing trend for them. Accounts were also responded to differently, with different identity attributions made, depending on level of the patient's English language fluency.

Implications: Nurses need to be aware of the way patient identities are actively shaped in the consultation (as good/compliant or bad/non-compliant, or in terms of capacity to speak English and therefore demonstrate knowledge), and the effect on talk relating to patients' accounts of their health behaviours. This has particular implications for

key indicator exploration and self-management talk. We will make some recommendations for practice.

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.

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The University of Melbourne

Pharmacists' medication communication with healthcare professionals in speciality hospital settings

Background: Effective communication between healthcare professionals about patients' medications is pivotal to shared decision-making and safe medication management. This paper explores the sociocultural and environmental influences shaping pharmacists' and other healthcare professionals' medication communication, the actual communication interactions and outcomes of these encounters.

Methods: This ethnographic study draws on 41 semi-structured interviews with healthcare professionals (nurses, doctors and pharmacists), patients and family members in five specialty settings of a hospital, and 90 hours of participant observation of healthcare professionals in two of these settings. All observations and interviews were audio recorded and transcribed verbatim. A thematic analysis was performed.

Findings: Key sociocultural influences on pharmacists' communication were time constraints, perceived urgency of situations, and healthcare professionals' roles, experience and expertise. Environmental influences included ward spatial design and lack of staff visibility. Most notably these influences contributed to repeated communication interactions initiated by pharmacists for doctors to review errors in patients' prescribed medications.

Healthcare professionals' preference for face-to-face communication drove encounters that were opportunistic, however, pharmacists and doctors were not always present on the ward. Additionally, pharmacists did not participate in medical ward rounds due to time constraints. Asynchronous communication through pagers, patient medication charts and notes, and whiteboards was used. Untimely resolution of medication issues resulted in medication errors and delayed patient discharge.

Implications: To facilitate timely decision-making and safe medication management, a culture needs to be fostered that promotes collaborative medication communication between doctors, pharmacists, nurses and patients.

Marie-Thérèse Rudolf von Rohr

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"Everyone's quit journey is different": Comparing persuasion on two smoking cessation websites

Background and objectives: This paper looks at the health risk "smoking" on two smoking cessation websites in the UK. The focus is on how these websites persuade their users to become active (e.g. buy medication, get support, etc.). In this written context, persuasion takes place predominantly through language. Therefore, in the analysis, emphasis is put on what the main arguments are, what speech actions are used and how these are linguistically realized. Additionally, relational work, that is "the work people invest in negotiating their relationship in interaction […],"(Locher and Watts 2008: 78) is important for persuasion. How said websites negotiate the relational aspect of communication is crucial, as they want users to follow their recommendations and accept their claims.

Data and Method: Both websites are publicly accessible, situated in the UK and are professionally maintained, but differ in their associations – charitable versus commercial. Both want to inform and ultimately reduce or prevent the health risks caused by smoking by inciting users to change their behaviour. In a qualitative content analysis, salient arguments, main speech actions and relational strategies are identified. These are cross-referenced to highlight linguistic patterns.

Results and implications: While core arguments (health risks of smoking and benefits of quitting) overlap on the websites, the speech actions, their interpersonal effects and linguistic realizations can vary greatly within the same topic (e.g. in terms of mitigation, pronoun use, etc.). These findings can be attributed to the different goals of the websites and show the importance of making fine-grained linguistic analyses to describe persuasion in online health practices.

Rachel Rowe

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Harnessing cultural perspectives to enhance alcohol and other drug treatment

Background: Engaging cultural perspectives has been shown to enhance treatment outcomes for substance use issues and co-occurring mental health issues among culturally and linguistically diverse (CALD) communities. Few services document the way they provide services to CALD clients. This paper responds to this gap by exploring the ways in which alcohol and other drug (AOD) counsellors at a specialist service balance cultural relevance with fidelity to a combination of psychosocial interventions.

Methods: Semi-structured, in-depth interviews were conducted with all counsellors (n=6) and half of the clients (n=24) at an AOD counselling service in Sydney, NSW. Interviews employed screening questions to explore the combination of counselling techniques, alongside bilingual counselling roles and information provided to clients about counselling at the service. Interviews were conducted in four major languages spoken by clients of the service: Arabic (n=1), English (n=16), Mandarin (n=2) and Vietnamese (n=5).

Findings: This paper identifies 10 strategies for culturally relevant treatment, including addressing clients' understanding of counselling, offering counselling in the client's preferred language and enquiring about the importance of cultural identity to each client. Counsellors reflected upon the interpretability of psychosocial interventions in particular languages, and explained flexible responses which integrate elements of cultural philosophy and communication styles into the practice of counselling.

Implications: Aboriginal and Torres Strait Islander services continue to demonstrate the role that culture can play in enhancing treatment outcomes. Following this example, further research that interrogates a "one-size fits all" approach with culturally diverse clients is called for.

Silvia Riva & Peter Schulz

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Judgment and decision making (JDM) in the frame of health literacy: The fil rouge of research

Background: A full range of processes, factors and mechanisms has been put into play to explain judgment and choice phenomena in health contexts, as shown by an established corpus of literature in psychology and cognitive sciences. However, over the past few decades, judgment and decision making (JDM) behavior has been recognized as a critical determinant of successful or unsuccessful health management also in other disciplines. Particularly, patient's skills in understanding, applying information and making judgments have been conceptualized in the frame of Health Communication, with a number of important studies in Health Literacy (HL). However, issues related with mental reasoning and judgment processes are usually considered separately in both fields - psychology and health communication- determining a sort of scission between two disciplines that, instead, could fruitful cooperate together in this research topic .

Aim: The aim of this literature review was to evaluate which are the main factors/skills of medical JDM evaluated by current psychological literature (1st objective) and to consider how health literacy research, that represents an emergent and innovative construct in health contexts, could profit from the results of this established corpus of literature (2nd objective).

Methods: An extensive literature search was performed in a number of database searches to identify articles reporting JDM factors/skills in healthcare contexts analyzing patient/user's point of view. Experimental and observational studies (e.g., focus groups, surveys, interviews), conceptual and review articles were included. The literature review aimed to identify recent research; therefore appropriate databases were searched for English language articles dated from 1998 to December 2012. Sixty-three paper were selected.

Findings: Several factors have been found to be critical in the involvement of JDM in health contexts focusing on patients' perspective. These factors are related with cognition, self-regulation, emotion, knowledge, and social representation. Health literacy research can profit from this literature overview, first, by elaborating on the idea that judgment is a multidimensional process where several individual mechanisms interfere, and second, by recognizing the weight of these mechanisms to helps people to orienting judgments in effective and positive decisions for their health, that represent one of the most important outcome in HL interventions.

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Coping with lower back pain: survey results in the three language regions of Switzerland

Introduction: Leventhal's commonsense model of self-regulation has triggered much research in recent years, but its possible implications for understanding people's coping with lower back pain have received attention only recently.

Aim: The aim of this study is to explore (a) the causal factors to which persons with lower back pain attribute the further course of their illness, (b) to find out whether the attributed causes are predictors of coping maxims, and   (c) whether cultural factors moderate the relationship between causes and coping.

Methods: A total of 1259 participants   were recruited in the three language regions of Switzerland. They were asked to complete a structured online interview, measuring among many other variables attributed causes, coping maximes, and cultural affiliation proxied by language.

Results: The results show that attributed causes of the illness predict coping maximes. Cultural affiliation impacts on coping maximes independently, but culture does not moderate the relationship of attributed causes and coping maxims. or.

Implications: The results of this study have some important implications. Particularly, there is a need for longitudinal studies that are essential for confirming the direction of causality that cross-sectional research cannot. Such studies would also make possible a proper examination of Leventhal's model over time and suggest possible changes in its structure. This may well be of critical importance to understand representations of lower back pain but also chronic illness in general.

Bettina Sletten Paasch

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Health care practitioners' use of wireless phones in hospital settings can affect interprofessional communication and patient encounters

The use of wireless phones in hospital units are increasing, inducing practitioners to carry a working phone each. A qualitative study was performed in a medical hospital unit, investigating their effect on client-professional encounters and interprofessional communication. Participant observations were conducted in accordance to Spradleys methodology. A total of 30 hours were observed, and ethnographic interviews including 5 practitioners and 10 patients were performed. A hermeneutic approach was maintained during data analysis.

The study demonstrates a change in the way health care practitioners contact each other, using the phone although physical close. They tend to prioritize the wireless phone above the situation in which they are engaged, using nonverbal gestures to retract, and then have a conversation on the phone in front of the patient. Repeated calls were seen to affect the practitioners´ attentiveness, causing patients fear or lack of comprehension to escape their notice. In such situations it was obvious how the practitioner's ability to conduct compassionate care was compromised. Not perceiving the patients need of comfort and explanation restricted the patients trust, consequently influencing their relation.

Wireless phones were also shown to compromise patient safety. They interrupted medicine administration thereby increasing the risk of errors. Repeated calls were seen to disturb the practitioners' concentration, causing mistakes in the procedure they were performing.

The results emphasize the necessity of further investigations into the effect of wireless phones in health care settings. Equally, efforts should be made to define and develop the use of wireless phones in hospital units.

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*Fitness-to-Practice concerns in undergraduate medical education:
Stakeholder perspectives*

The subject of fitness-to-practice (FTP) concerns in the health professions is a topic of considerable interest both in Australia and overseas. Alongside the now vast literature concerned with professionalism, the establishment in 2010 of a new national regulatory and accreditation authority in Australia (The Australian Health Professions Regulatory Authority; AHPRA) creates a sharper focus on student behaviour and wellbeing, and the nature and extent of FTP issues in pre-service medical education. "FTP concerns" encompass a wide range of issues that can be broadly divided into pastoral care matters on the one hand (e.g. depression and anxiety), and behavioural issues on the other (e.g., disrespectful behaviour towards staff and/or patients). Both will be considered in this paper, with a particular focus on pre-service medical education in a regional clinical school context, however many of the issues covered also pertain to related health professions, such as nursing, pharmacy, and psychology and apply equally in non-regional clinical education contexts. Data derived from a qualitative investigation into the views and experiences of a range of key stake-holders will be reported. One-to-one in-depth interviews were conducted with 13 informants, ranging from senior faculty staff to Year 5 MBBS students, in order to gain an understanding of the types of issues that arise in an undergraduate cohort and the ways in which these are (or are not) identified and managed by staff. Informants' views regarding the pros and cons of mandatory reporting were also sought. Key themes and implications will be discussed in relation to ways of strengthening medical education and promoting patient safety.

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The "worried well" and "upper-mid" HIV/AIDS test takers: Discourse patterns as possible clues to personal characteristics of users on a Taiwanese online HIV/AIDS forum

With advances in Internet technology, the importance of online healthcare consultation increases rapidly. Moreover, it is expected that rising number of patients who find it inconvenient or embarrassing to seek help in face-to-face clinical encounters, especially patients who suffer from stigmatized disease, such as homosexuals or AIDS patients, will turn to online medical consultation. As a follow-up study of a series of investigations of Taiwanese online HIV/AIDS inquiries, the present report focuses on discourse patterns that reveal social and personal features of the online users in a Taiwanese AIDS/HIV forum. Our analysis of 154 extracts of HIV/AIDS related inquiries demonstrates the following language patterns: the use of medical jargons (e.g. "antibody test, negative"), citation of test items and results (e.g. "PCR<50" "ELISA HIV COMBO ab+ag, negative" "CD4 counts"), reports of repeated self-paid tests, and suspicion of the HIV negative results (i.e. uninfected by AIDS). These patterns further manifest the users' possible social and personal background of "upper-mid" "worried-well" homosexuals. Aware of the uncertainty of medicine, these over-worried users tend to hold suspicion toward their test results and thus repetitively take more HIV tests even though the previous ones have proven to be negative (i.e. HIV-free). Furthermore, the application of pseudonym (3%) and anonymity (97%) highlights the users' fear of public stigma against both homosexuals and HIV/AIDS patients. To provide a more adequate assistance and prepare for the future users in need, it is recommended that Taiwanese authorities establish a more thorough and satisfactory online healthcare system.

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Knowledge translation for consumers: development of an evidence-based health information website

Background: Consensus is building about summarising evidence in ways consumers can understand but research shows this isn't enough to make evidence relevant and usable for decision-making. This project's aim was to generate a model for presenting evidence-based health information online that is meaningful and personally applicable for people with multiple sclerosis (MS) and family members.

Methods: We developed a consumer health website using Cochrane reviews of MS treatments. Underpinned by knowledge translation principles, we sought formal and informal feedback from consumers (people with MS and family members), health professionals and MS Australia staff, in an iterative process. We conducted two group interviews (n=16 participants) with paper documents and, after revisions, developed a pilot website and undertook user testing (n=9 participants).

Findings: The website format reflects participants' preferences for layered information complexity (i.e. 'The short answer' and 'The detailed answer') and a combination of words, numbers and pictures to explain statistical information. The addition of two sections; 'Does this apply to me?' and 'Questions for my health professional', which aid personal applicability and a desire to share information with doctors, were strongly endorsed. Consumers were seeking more information than evidence alone provides, which we partially addressed by adding external web links. Consumer concerns around information credibility resulted in an explanatory section about Cochrane reviews and an FAQ page.

Implications: The web site is currently being evaluated, but results to date suggest that information providers could consider consumer information format preferences, addressing credibility and personal applicability and providing further online information sources.

Helen Tebble

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The accompanying spouse in the interpreted medical consultation

Issue: Up to now our research (e.g., Hirsh, 2001, Tebble 1993, 1999, 2009) has established the nature of the genre of the interpreted "classic" medical consultation comprising the English speaking consultant physician, the patient who speaks a community language and the professional medical interpreter. However the role of the patient's accompanying spouse in such consultations has not been investigated and is given only cursory attention in interpreter education. This progress report from the project 'Cultural and Linguistic Aspects of Interpreted Discourse' investigates the role of the accompanying spouse for the elderly Italian speaking patient.

Methods: The data are drawn from audio-recorded interpreted medical consultations, transcribed to the level of the tone group, using modified conversation analysis conventions. Systemic Functional Linguistics is used to describe their generic structure (Hasan 1985). Each participant's role relationship with the spouse are analysed for their tenor following Martin (1992) and Tebble (1999); and using Appraisal Analysis (Martin and Rose 2007) for their interpersonal attitudes. Code switching and turn distribution for all participants (Tebble 1996/2004) will be identified.

Findings: The accompanying spouse will modify the contextual configuration but not the genre. The tenor and Appraisal findings will provide not only role descriptions of the accompanying spouse (e.g., supporting listener, spokesperson, reliable informant), but also ways the interpreter negotiates turns at talk due to the participation of the spouse.

Implications: Strategies for managing multiparty talk in two languages in medical consultations that entail a variety of interpersonal roles and attitudes will be identified for medical interpreter and physician communication education.

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Demystifying addiction through personal stories – An online educational resource

Background and Objective: A new free online educational resource has been developed by health researchers at the University of Otago Wellington School of Medicine and Health Sciences which aims to provide information about addiction (in particular recovery from addiction) from the service user perspective to medical and other health professional students. This presentation will showcase the pilot resource.

Methods: A small number of people who have experienced alcohol and other drug (AOD) addiction were interviewed about their experiences, what motivated them to change, what recovery means for them and what helped and/or hindered them in that process.

Findings: Five common themes were identified and have been illustrated in the resource with selected video clips and corresponding transcripts. The broad theme titles are Personal, Recovery, Health Professionals, Trauma and Mental Illness and include a number of sub-themes. The resource also includes an exercise for students to critically self-reflect on their attitudes towards addiction and current practice, and a survey for user/stakeholder feedback. This feedback will be used to inform a proposed larger research project in which a wider, more representative sample of service users will be interviewed.

Implications: By providing access to personal stories, we aim to help students develop a broader understanding of addiction, facilitate an empathetic, non-judgmental, collaborative approach to sensitive topics such as substance abuse, and improve consultation competence and confidence in initiating AOD discussions, exploring problematic use and supporting behaviour change.

Mei-hui Tsai

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Teaching Taiwanese for medical purpose: A pragmatic approach to patient-centeredness and dialect preservation

As true in most societies where the aging population is growing but the number of young speakers of the local dialects is decreasing, medical practice in Taiwan is facing a worrisome language barrier, since many young professionals cannot speak Taiwanese, the only language of many elderly patients. By examining Taiwanese doctor-patient conversation, this paper demonstrates communication problems resulting from this language barrier and argues for the importance of establishing the language course 'Medical Taiwanese'. The problems include doctors' code-switching into Mandarin, the official language in Taiwan, when discussing medical terms, simplifying the diagnosis and explanation when presented in Taiwanese, or directing the discussion to the patient's young companion. These problems lead to inefficient information-exchanging and poor doctor-patient relationship. We thus argue that the implementation of teaching medical Taiwanese will (1) match the goal of the rising approach of LSP—teaching language for specific purpose tailored to medical students' future career needs; (2) fulfill the medical professionalism of patient-centeredness by practicing narrative medicine, evidence-based medicine, and informed decision-making, via first-hand communication in the patients' mother tongue; (3) promote dialect preservation by social elites, such as doctors, via speaking in patient's 'life-world language' (Mishler 1984), in contrast to the 'medical world language' used in English textbooks or Chinese lectures in most medical schools in Taiwan; and (4) increase dialect vitality by extending the formal medical lexicon in Taiwanese.

Franziska Thurnherr

University of Basel

"Together, we will look for the path ahead and the life you can make whole again." The relationship between therapist and client in email counseling as the driving force for change

Background: This paper investigates the relationship between therapist and client (henceforth 'therapeutic alliance') in online counseling from a linguistic perspective. The therapeutic alliance is especially important since it is a driving force for a client to change for example unconstructive behaviors collaboratively with the therapist. The concept of relational work (Locher and Watts 2008: 78) – defined as "...the work people invest in negotiating their relationship…" – is used as the linguistic framework to account for interpersonal aspects of the language used. Constructive

Research Questions: The following research questions are looked at: What kind of relational work (and its linguistic realization) is carried out to enhance the therapeutic alliance? How are relational strategies (e.g. empathizing, bonding, hedging) sequentially used throughout the therapeutic alliance? Is there a clear preference for certain strategies at certain points in time throughout the exchange?

Methodology and Data: The chosen methodology is a discourse analytic approach and of qualitative nature. The data – obtained from a counseling service of a British university – is naturally occurring, in written form, and consists of several email exchanges between therapists and their clients.

Results and Implications: The results outline that two aspects are important: the continual work as a team and the clear delineation of the client as the active changer. The former can be realized through relational strategies evoking involvement and the latter through relational strategies enhancing face. These findings suggest that the choice of linguistic realizations is crucial in first establishing and then maintaining a positive therapeutic alliance.

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How nondirective are genetic health professionals when parents request genetic carrier testing in healthy children?

Background and objective: In genetic counselling involving decision making, nondirectiveness is often discussed as the ideal communication style. Nondirectiveness refers to the idea that an adult's autonomous capacity to make decisions about themselves should be respected. Yet when parents make decisions about genetic testing in their children, the concept of nondirectiveness becomes more complex as the autonomy of both parents and their children requires consideration. This study aimed to investigate how genetic health professionals communicate with parents about genetic carrier testing in their healthy children and whether their reports about their communication fit a traditional nondirective model of genetic counselling.

Methods: Interviews were conducted with 17 genetic counsellors and clinical geneticists about their experiences of receiving and responding to requests from parents for carrier testing in their healthy children. Transcripts were analysed using interpretive content analysis with a specific focus on how the health professionals report communicating about carrier testing.

Findings: Three main categories were identified from the data: 1) discussions about testing other children, 2) recommendations for timing of testing and disclosure and 3) use of counselling skills. All participants initially recommend or advise against carrier testing with some pre-emptively raising that carrier testing is not usually performed in children. This strategy may potentially shut down communication and could be viewed as a form of directiveness.

Implications: This study prompts consideration about the role of nondirectiveness when providing testing for young children.

Identification of this gap between theory and practice in this area may provide insight into how to better link the two.

Sally Warmington

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"I don't know how to cut them off": Multi-voiced narrative and the struggle for an integrated professional identity

The formation of a professional identity is a vital part of a medical student's education. Students come to their training with multiple established identities, associated with certain attitudes and values, with which their emerging identities must coexist. It has been proposed that the nature of the relationship between emerging and pre-existing identities may influence students' capacity to develop empathy; however, this has received little research attention. Because storytelling is an important means for the construction and performance of identity, it forms the basis for this study.

The narrative material on which this paper is based was collected during a semi-structured interview with a medical student, as part of an ethnographic study into encounters between students and patients in a teaching hospital. The story was submitted to a dialogic narrative analysis in order to explore the complex process of identity formation.

Substantial identity work is accomplished by the student as she performs her 'multi-voiced' story. She juxtaposes three versions of her own 'voice' with that of her tutor, as she tells of her struggle to reconcile the conflicting demands of the situation. Rather than uncritically complying with her tutor's instructions, she works to construct a new identity which can be integrated with her pre-existing 'selves.'

This work confirms the utility of narrative methods in the investigation of this critical but under-researched aspect of a medical professional's development. Further investigation is required to explore the ways in which the relationship between an individual's identities is shaped by local cultures, practices and environments.

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"Consent is a bit different with procedures": Fear, desire and identity in narratives of 'customary' consent practices

It has been acknowledged that there are discrepancies between practices advocated in medical schools for obtaining consent from patients, and those commonly practised in a teaching hospital. This paper explores one student's story about gaining access to patients to practise procedures during clinical training.

The narrative material on which this work is based was collected during a semi-structured interview with a medical student, as part of an ethnographic study into student-patient encounters in a teaching hospital. Using dialogic narrative analysis, I explore how customary practices of obtaining patient participation in students' learning are related to their identity formation.

When approaching patients about technical procedures, students observe that it is customary to withhold information about their novice status, and not to offer the option to have an experienced person perform the task. These practices are defended on the grounds that students would receive insufficient experience if valid consent were to be obtained. Stories about learning to perform procedures on patients reveal the interactional power dynamics, as well as unspoken desires and fears, potentially arising from unwarranted assumptions. Students may struggle against, but also comply with customary practices as they actively construct their professional identities.

Some customary practices are inconsistent with the high standards of integrity claimed by the medical profession, to which students are expected to aspire. This may influence their emerging identities, with implications for their future disclosure and consent practices. This study highlights the need to engage all those involved in a critical dialogue about this thorny problem.

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Playing it by ear? Caregiver recall and understanding of diagnostic information and assessment feedback in paediatric audiology consultations

Background and objective: Providing appropriate feedback and ensuring understanding of recommendations is an important aspect of medical interactions. In paediatric consultations, caregivers' understanding and recall of information may have significant implications for a child's health and development. This preliminary study explored information giving practices and caregiver recall and understanding of feedback after a paediatric audiological assessment.

Methods: A qualitative study was conducted at a South African audiology clinic. Participants included four audiologists and five caregivers whose children had been referred for an audiological assessment. Data collection included video-recording of assessment and feedback sessions, and post-session semi-structured interviews with participants. Recorded sessions were analysed using sociolinguistic methods and a transcription-less approach that focused on audiologists' information giving strategies and caregivers' verbal and nonverbal responses. Interviews were analysed via content analysis.

Findings: Feedback sessions included explanations of the hearing mechanism, audiological tests, diagnosis and recommendations. Audiologists attempted to simplify concepts and repeat information but analysis revealed limited information tailoring to caregivers' communication needs and a tendency towards 'information dumping'. Caregivers contributed minimally during feedback sessions, they could recall the diagnosis and recommendations but not the explanations of the hearing mechanism and audiological tests, and the use of pictures resulted in greater misunderstandings.

Implications: The analytic methods used in this study highlight the importance of tailoring information giving towards caregivers' communication needs and selecting relevant information to convey during feedback sessions. There is a need for greater emphasis in curricula on the nuances of information giving, and several suggestions will be made in this regard.

Tina-Marié Wessels[1] & Claire Penn[2]

Division Human Genetics, University of the Witwatersrand and the National Health laboratory Service, Johannesburg, South Africa[1]; Health Communication Research Unit, University of the Witwatersrand, Johannesburg, South Africa[2]

"So the doctors saw you…" How context shapes Genetic counselling interactions Johannesburg, South Africa

Background and objective: Genetic counselling (GC) practices originated in the USA and UK, and as services and the client base expanded to other countries, questions have arisen as to the effectiveness of the service to clients in these settings. In South Africa, genetic counsellors who are involved in counselling women of advanced maternal age (increased risk of having a baby with a chromosome abnormality) report poor uptake of services. The present study was undertaken to explore these interactions.

Methods: In this intercultural setting, 17 interactions between genetic counsellors and their clients were voice and video recorded, transcribed and analysed drawing on elements of discourse analysis.

Findings: Results suggest the marked impact of context on aspects such as how the counsellors set the agenda; how they guided the women through the process and how they assisted with decision-making. Discourse methods appeared powerful in allowing the nuances of these interactions to emerge and showed how context shaped the genetic counselling agenda, the strategies the counsellors developed and the tensions created during decision-making.

Implications: The research suggests a need for change in traditional models of genetic counselling and the importance of acknowledging contextual features in clinical practice.

Sarah J. White[1] & Israel Berger[2]

Macquarie University[1]; University of Roehampton[2]

Teaching skilled clinical communication: Using audio-visual recordings of actual clinical communication to enhance clinicians' reflective communicative practice

Background: The teaching of "communication skills" can be abstract communication from clinical practice and assumes that "skills" are universally transferrable and generalisable. By contrast, in this project we focus on "skilled communication". Skilled communication is an integrated set of abilities, such as making good communicative judgment, having confidence in managing uncertainty, and trusting in one's own unique expression [1]. In order to support development of skilled communication, we piloted the Conversation Analytic Role-Play Method (CARM) [2].

Methods: CARM, which has been used in other institutional settings, provides a systematic and structured approach to engaging with recordings of actual interactions. Using a methodology such as CARM ensures that there are no issues of authenticity, as there can be in simulated role-play [2]. CARM uses transcribed vignettes of recordings of actual clinical interactions. These are presented line-by-line with the audio and the transcript synchronized on the screen. After one (or several, as appropriate) turn at talk has been played, participants work together to discuss the possible interactional difficulties, discuss how they might have managed that part of the interaction, and formulate possible next turns. Those turns are then revealed and discussed.

Findings: CARM allows participants to engage with actual clinical interactions and reflect on communicative practice in an interactive way. In this presentation, we will discuss the design of the workshops, using examples of vignettes and transcripts. We will also present the evaluation of the workshop along with our recommendations for future work using CARM in communication education for health professionals.

Allison Williams[1] & Elizabeth Manias[2]

Monash University[1]; The University of Melbourne[2]

A qualitative analysis of people's motivation and confidence in taking multiple prescribed medicines

Co-existing chronic illnesses are increasingly prevalent as our population ages. Taking multiple medicines as prescribed is a core task in the self-management of co-existing chronic illnesses. The aim of this paper is to explore the motivation and confidence of people with the commonly co-existing chronic illnesses of diabetes, kidney disease and hypertension to take their medicines as prescribed.

A qualitative analysis was conducted on a series of motivational interviewing telephone calls with 39 patients with these key conditions in the intervention arm of a randomized controlled trial. Patients aged ≥ 18 years of age were recruited from nephrology and diabetes outpatients' clinics of two Australian metropolitan hospitals in 2009.

Thematic analysis revealed four major themes which related to the complexity of multiple health problems, active self- management, trying to self-manage, and discontent with the medical model of health care. For most participants, having to take multiple medicines at various times of the day, no matter how well-intentioned, was disillusioning and negatively affected their motivation and confidence in this task. Self-management of co-existing diabetes, kidney disease and hypertension is an unending vocation, highlighting participants' quest for personal control of health and the various coping strategies participants' used in an attempt to achieve this. A greater understanding of adherence to prescribed medicines is critical due to the increasing quantity of medicines prescribed. Access to person-centred support that addresses the emotional difficulties associated with having to take multiple medicines is necessary.

Stella Williams, Farid F. Youssef & Dexnell Peters

University of the West Indies

Ethics and professionalism in medical education – Shades of grey?

Emphasis on the biological and technical aspects of teaching medicine can result in decreased concern for humanitarian values. Whilst these were traditionally the natural concern of those who entered the profession, twenty first century ideologies are sufficiently self-seeking and individualistic that our trainee doctors do not necessarily hold their patients' overall welfare as central. This problem is not only evident in a developing society in the Caribbean, it is also global. In order to reinforce the humanitarian values associated with the medical profession, curriculum intervention has been suggested as a way to inculcate such values to the profession. Professionalism and ethics therefore need to be explicitly taught to re-establish the profession's historical roots, its strong moral base and its full social contract with society. This report is located at a medical school where students are now wrestling with ethical and moral issues in their professions that are informed partly by the hidden curriculum. It describes the process of creating and implementing a five-year curriculum that weaves ethics, professionalism and communication into the existing medical programme. Sources of data include contributions from a Faculty retreat, a needs assessment, feedback from an informal pilot and first year students' essay assignments on the topic of ethics and professionalism. Findings point to a lack of a moral compass and bewilderment among our students as it pertains to ethical issues. Since ethics and professionalism are foundational pillars of medical education there is urgent need to infuse the entire curriculum with a formal training programme.

Mary Wyer

University of Technology, Sydney

Involving patients in understanding infection control using visual methods

Background and objective of the paper: Healthcare interactions around infection control contribute to patient understandings of healthcare acquired infection (HAI) and the roles they play in preventing transmission. Extant research on patient experiences of HAIs has been conducted using survey, psychometric tools or interviews capturing people's thoughts and feelings at only one point in time. In this paper, I address the potential of video-reflexive ethnography, in the context of an investigation currently in the pilot phase, for exploring how hospitalised patients and their carers experience and manage the diagnosis of a multi-drug resistant organism (MDRO).

Methods: Video-reflexive ethnography involves participants producing and making sense of visual data. Visual narratives around infection control, gathered by the patients themselves or in collaboration with a facilitator throughout their hospital stay, are condensed into visual vignettes and used in one-on-one reflexive sessions between patient and researcher where participants view footage of their involvement in infection control practices and reflect on how their needs and actions intersect with infection control practices in the hospital.

Discussion and findings: While ethical issues and limitations must be negotiated, video-reflexive ethnography is a valuable method that can facilitate patients in a) articulating their understandings of infection control as they are experiencing it and b) determining better ways to have their health needs met.

Implications for clinical practice and health care policy: There is worldwide recognition that healthcare services must become more responsive to consumer needs. Video-reflexive ethnography can provide compelling and otherwise unavailable patient feedback to clinicians and policy-makers that can inform patient-centred re-design of infection control services.

Jill Yamasaki

Valenti School of Communication, University of Houston

The communicative role of companion pets in patient-centered critical care

Background and Objective: This study examines the novel ways companion pets facilitate meaningful communication between patients, providers, and families in hospital settings. I focus on PAWS (Pets Are Wonderful Support) Houston, a nonprofit organization dedicated to preserving the human-animal bond between people and their personal pets (rather than those trained for therapy) during extended hospitalization for chronic or terminal illness. This unique pet visitation program is available with a physician's order to patients in all major hospitals located in Houston's Texas Medical Center, the largest medical complex in the world. Volunteers facilitate approximately 25 personal pet hospital visits each month, with most occurring in critical care.

Methods: I sought a holistic understanding of the PAWS Houston program through a variety of ethnographic methods, including participant observation; informal interviews with providers, patients, and their families; semi-structured interviews with PAWS personnel; and discourse review of organizational materials. I employed a method of constant comparison to identify and thematically analyze recurrent patterns of behavior and overarching meanings across the data.

Findings: Three primary themes regarding the communicative role of companion pets in patient-centered critical care emerged from the data: (a) compassion, (b) connection, and (c) response. Collectively, the presence of pets prompted stories and behaviors that foster healing relationships characterized by empathy and mutual understanding between patients and providers.

Implications: Personal pet hospital visits facilitate storied conversations and alternative ways of knowing that promote greater understandings of the patient's psychosocial context for more personalized care and improved wellbeing during chronic or terminal illness.

Lynda Yates[1], Maria R. Dahm[1] & Sandy McManus[2]

Macquarie University[1]; Postgraduate Medical Education Council of Tasmania[2]

"There is nothing this blue in nature" – Use of informal language strategies among non-native international medical graduates (IMGs) in clinical examinations

Background and objective: The majority of international medical graduates (IMGs) in Australia's medical workforce are non-native speakers of English, come from diverse linguistic and cultural backgrounds and have received different medical training from their Australian colleagues. Before being allowed to practice in Australia, most of these internationally trained doctors need to pass the two part Australian Medical Council (AMC) examinations testing their medical knowledge and communicative competence. IMGs often struggle with more "informal" communication strategies such as adopting a conversational stance or including vague language, however, despite the growing reliance on IMGs, multi-dimensional investigations into their communicative challenges are still rare.

Methods: This study investigates IMGs' problems with informal language by combining analysis of video-recorded AMC mock exams, with examiner and role-player feedback. Mock exams were transcribed and analysed for features of "informal" language and results were compared with examiner and role-player feedback to check whether informal language featured in their assessment of IMGs' performance.

Findings: Feedback regarding communication, rapport, empathy and patient-centredness often touched upon informal language skills but rarely addressed these valuable communicative strategies explicitly. It is argued that "informal" strategies merits inclusion in professional intercultural communication courses assisting IMGs in strengthening doctor-patient relationships and overcoming intercultural communication barriers.

Implications: This pilot study shows how multifaceted research can help to increase our understanding of IMGs communication difficulties as

perceived and assessed not only by test examiners and role-players but also by applied linguists, and makes a strong case for the adoption of evidence-based approaches in studying IMGs difficulties and developing better-integrated communication training courses.

Valerie Youssef, Stella Williams, Farid Youssef & Dexnell Peters

The University of the West Indies

When the foot reaches the knee: Health literacy and the burden of communication re-examined

Background: Definitions of health literacy mention not just reading, writing and numeracy but cultural and conceptual knowledge and oral communication skills (e.g. IOM, 2004). These are the foci of the current paper which seeks to examine the cultural knowledge and language that individuals bring to their health care and related communication problems. The study's site is Trinidad & Tobago whose multi-cultural population consists of majority groups of African and Indian descent, a growing mixed population, and others. The majority were wrenched from their own cultures by slavery and indenture, but retain their cultural beliefs and have developed local language to accommodate these.

Objective: This paper surveys the medical language of Trinidad and Tobago and interrogates patient health care experience as it relates to bi-varietal communicative competence. Medical student knowledge and receptiveness to local terms is interrogated through a questionnaire, and a subset of interactions between health-care providers (HCP's) and their clients is interrogated for instances of communication difficulty related to inter-varietal communication.

Findings: Trainee HCP's were found to have limited responsiveness to local terms and beliefs and interactions between HCP's and their patients indicate communication challenges.

Implications: Ultimately it is suggested that HCPs need familiarity and willingness to treat with the lexicon of their clientele to achieve mutual understanding. The onus is not just on clients, who may not have the means to move beyond their cultural understandings, but on the HCPs, to close this communication gap.

Claudia Zanini[1,2]; Paolo Maino[3]; Jens Carsten Möller[3]; Claudio Gobbi[3]; Monika Raimondi[3] & Sara Rubinelli[1,2]

Department of Health Sciences and Health Policy, University of Lucerne, Switzerland & Swiss Paraplegic Research[1]; Swiss Paraplegic Research (Nottwil, Switzerland)[2]; Neurocentro della Svizzera Italiana, Lugano, Switzerland[3]

Five-questions to facilitate an agreement with the patient: Results from a qualitative study

Background and objective: Diagnosis are often formulated on the basis of the exchange of information during the anamnesis. Traditional anamnesis includes a number of routine medical questions (e.g. on symptoms and treatments). The objective of this study is to show that a set of five questions – not routinely asked in the anamnesis – can facilitate an agreement between doctor and patient over the course of action.

Methods: Semi-structured interviews were conducted with a group of physicians from the institute of neurology in the Italian part of Switzerland (N=8) and with a group of Italian physicians expert in the field of fibromyalgia (N=17); video recordings of medical consultations (N=25) in the field of chronic back pain and chronic headache and post-consultation semi-structured interviews with doctors and patients. For data analysis, argumentation theory and grounded theory were applied.

Preliminary findings: The analysis highlights three aspects of the patient's perspective which are important in building an agreement between doctor and patient over a course of action. These are 1) the patient's beliefs about his condition and its causes, 2) the patient's expectations, and 3) his point of view on treatments (past, current, future). These aspects can be captured through five specific questions. Extracts from the medical consultations are presented to illustrate the value of these questions in identifying the appropriate treatment.

Implications: The findings of this study enhance the theory and practice of the medical consultation by identifying aspects of the patient's

perspective that are important to facilitate the building of an agreement with the doctor.

Olga Zayts[1] & Srikant Sarangi[2]

University of Hong Kong[1]; Cardiff University[2]

'Treat him as a normal baby': Paediatricians' framing of parental responsibility as advice in the management of a genetic condition

Parental responsibility in the management of genetic conditions has been the focus of both family-oriented interview-based research (e.g. Arribas-Ayllon et al. 2008; 2011) as well as real-life face-to-face genetic counselling research (Sarangi fc; Thomassen and Sarangi 2012). The current paper is an attempt to contribute to the latter tradition involving paediatricians and parents where parental responsibility is constitutive of professional advice. The genetic condition in question is G6PD deficiency (commonly known as favism), a mild hereditary disorder prevalent in Asia (Zayts and Sarangi 2013).

We draw on 18 consultations in a maternal unit in Hong Kong (recruitment ongoing) where paediatricians communicate with mothers of newborns diagnosed with G6PD. We employ theme-oriented discourse analysis – comprising activity analysis and accounts analysis (Sarangi 2010) – to examine how the paediatricians frame their advice-giving trajectories – on to which elements of parental responsibility (in terms of future actions and moral selves) can be mapped. We show how 'causal responsibility' (Sarangi, fc) that concerns potential consequences of the mothers' actions in managing the condition emerges as a dominant thread in our data corpus. 'Causal [parental] responsibility' is embedded in the paediatrician's advice-giving trajectories which include, among other things, how to 'treat' these children, ranging from safeguards against certain medications and food to prevention of negative physiological scenarios (such as an acute hemolytic reaction). We examine closely the attendant discourse devices through which parental responsibility is framed, e.g., modalisation, contrast, character/event work. We conclude that, in terms of temporality, 'causal [parental] responsibility' is 'forward-looking' as the mothers' responsible actions can normalise the child's immediate and future wellbeing.

Arribas-Ayllon, M., Sarangi, S., and Clarke, A. (2008) Managing self-responsibility through other-oriented blame: Family accounts of genetic testing. Social Science and Medicine 6: 1521-1532.

Arribas-Ayllon, M., Sarangi, S., and Clarke, A. (2011) Genetic Testing: Accounts of Autonomy, Responsibility and Blame. London: Routledge.

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Sarangi, S. (2010) Practising discourse analysis in healthcare settings. In I. Bourgeault, R. DeVries and R. Dingwall (eds) The SAGE Handbook of Qualitative Methods in Health Research, 397-416. London: Sage.

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POSTER SESSION

Friday July 12th

10:30-11:25am

Ground Floor Law Building

Moderator: *Srikant Sarangi* (from 10.45)

1. *Israel Berger, Sarah J. White* Who's who?: Constructing roles during minor awake surgeries

2. *Anne Kalvatsvik, Jan Ole Bolsø, Roar Stokken & Johan Barstad* DUGNAD – a communicative model for regional level to support municipalities regarding drug and alcohol issues

3. *Henry Kilham* Should children have special ethical consideration?

4. *Caitlin Longman, Claire Penn & Jennifer Watermeyer* The influence of isolation and identity on interprofessional communication in a rural hospital

5. *Terry Miller* IMG Communication Skills' Training in Victoria's Public Hospitals

6. *Johannes H. Österholm & Lars-Christer Hydén* Representing needs in assessment meetings: Persons with dementia applying for formal supportive services

7. *Susan Philip, Robyn Woodward-Kron & Elizabeth Manias* Intercultural communication in nursing: experiences and training needs of overseas qualified nurses (OQNs) in Australian health care

8. *Daniel McDonald*, Building a web-corpus of patients' online mental health communication for mixed-methods investigation

Israel Berger[1] & Sarah J. White[2]

University of Roehampton[1]; Macquarie University[2]

Who's who?: Constructing roles during minor awake surgeries

Background: Role performance and inter-personal dynamics of medical consultations have especially been examined in paediatrics (e.g., Clemente, 2010; Stivers et al., 2003). Although the dynamics of operating theatres have been examined in detail (Mondada, 2006), CA research has not looked at the dynamics of awake surgeries. Differences relevant to interaction exist between awake surgeries and general anaesthesia. Primarily, the patient is conscious and able to speak. In minor awake surgeries, such as cyst removal, the sterile field is smaller, the surgical team is smaller and may lack an anaesthesiologist, and the patient may be accompanied.

Methods: We used conversation analysis to examine a corpus of publicly available minor awake surgeries for ways in which diverse parties construct roles.

Findings: We discuss timing and content of talk, speakers' rights and obligations, and ways in which participants claim expertise and authority.

Implications: There are implications for medical communication education and inclusion of family and friends in the procedure room.

Clemente, I. (2010). Progressivity and participation: Children's management of parental assistance in paediatric chronic pain encounters. In A. Pilnick, J. Hindmarsh, & V. Teas Gill (Eds.), *Communication in healthcare settings: Policy, participation and new technologies* (pp. 83-98). Chichester, UK: Wiley.

Mondada, L. (2006). La compétence comme dimension située et contingente, localement évaluée par les participants. *Bulletin VALS-ASLA (Association suisse de linguistique appliquée), 84,* 83-119.

Stivers, T., Mangione-Smith, R., Elliott, M.N., McDonald, L., & Heritage, J. (2003). Why do physicians think parents expect antibiotics?

What parents report vs what physicians believe. *The Journal of Family Practice, 52*(2).

Anne Kalvatsvik[1], Jan Ole Bolsø[1], Roar Stokken[1] & Johan Barstad[1,2]

Møre and Romsdal HospitalTrust[1]; The Norwegian University College for Agriculture and Rural Development[2]

DUGNAD – a communicative model for regional level to support municipalities regarding drug and alcohol issues

Background and objective of the paper: Municipal authorities are responsible for drug and alcohol prevention and rehabilitation issues at local level. Regional authorities provide support and competence building. In a recent project, the Resource Center for Drug and Alcohol Issues in Central Norway provided structured support, aiming to enhance local capabilities in order to increase local authorities' capacity to deliver quality services.

Methods: This project was the object of a continuing evaluation, combining action- research methodology with classical ex‑post evaluation. The evaluation team participated in meetings and seminars, had a close dialogue with the evaluation team, discussing findings and reflections as a basis for implementing changes in policy and practice in real time. Further, 13 in‑depth interviews were conducted with central participants and stakeholders at municipal level – mainly public health coordinators. Findings Public health coordinator and how this position is embedded in the municipal organisation proved significant. Formal and informal networks around the coordinator were further of importance for successful processes at municipal level. We further found the representation in the local steering groups—and how directly they represented the interests of their base‑organisations to be significant. Municipalities where a trans-disciplinary steering group administered the work generally shoved more favourable results.

Implications: There oft is lacking understanding of how to support and promote mobilising processes, resulting in processes more instrumental than communicative. Our advice is that the regional authorities must focus on promoting positive mobilization processes and ensure the inclusion of all relevant stakeholder‑groups. Further that effort has to be spent on establishing common understanding of challenges and opportunities and strategies for how to reach the common goals.

Henry Kilham

Centre for Values, Ethics and the Law in Medicine, The University of Sydney; General Medicine, The Sydney Children's Hospitals Network, NSW, Australia

Should children have special ethical consideration?

Some but not all see children as especially precious and deserving of higher priority in ethical decision-making and resource allocation. Child care workers have potential conflicts of interest in this matter. It is worth re-examining the arguments for and against any special consideration for children:

Nutritional, emotional, educational, health care and social deprivation during childhood will all often irreversibly reduce potential flourishing in later life. Effective interventions in any of these are likely to have life-long benefits, so deserve priority. The counterargument is that all individuals should have equal ethical status and access to benefits.

Childhood can be seen as intrinsically valuable in itself, as a time for unpressured discoveries and joys, for relative freedom from fear and responsibility, for imaginative play and work as play as opposed to necessity. Alternatively it can be seen largely as a social construct for preparation for adult life, with attitudes, activities and education all directed towards that. The ethics of each approach varies greatly.

Without question, children require special care and protection, being totally dependent as newborns yet still vulnerable to specific harms as teenagers. Decisions about children are almost always made within their families and decisions will affect other family members, giving rise to complexity and potential conflicts when the interests of the child are compromised. Ethics of decision-making will vary greatly from where parents are given full autonomy, to where the preferences of the child are taken into account, which can be at much earlier ages than those given legal autonomy. Otherwise, the general principles applying to ethical discourse should be the same for persons of any age.

Caitlin Longman, Claire Penn & Jennifer Watermeyer

Department of Speech Pathology & Audiology, Health Communication Research Unit, School of Human and Community Development, University of the Witwatersrand, Johannesburg, South Africa

The influence of isolation and identity on interprofessional communication in a rural hospital

Background: Little research has been done on the role of interprofessional communication in a rural setting. The aim of this research project was to describe and understand communication between health care professionals working in a rural context. South Africa is a diverse country in terms of its cultures, languages, socioeconomic variety and community beliefs and this is reflected in the health care setting.

Methods: The research study used a qualitative design. 52 health professionals participated in interviews and focus groups, including doctors, nurses, clinical associates, social workers, pharmacists, dieticians, physiotherapists, occupational therapists, speech-language therapists, audiologists and admin staff. The data in this research was methodologically triangulated by using three different sources of gathering information: ethnography/observations, focus groups and interviews. Profession-specific vignettes were used during the focus groups to stimulate discussion. The data was explored using thematic content.

Findings: The study highlighted isolation of the hospital from both the wider medical community as well as the local community which influenced interprofessional communication. Other systemic influences included rural factors, changes in health systems and provincial support. One of the most prominent interpersonal themes to emerge was the identity of the health care worker which was interlinked with their professional role, status, power, responsibility, race, language and community identity.

Implications: This study adds to knowledge in this field as well as develops new research questions within the rural hospital environment.

The implications from this study are important for policy, theory and practice e.g. communication training programmes for rural healthcare teams as well as site specific models of training.

Terry Miller

The University of Melbourne

IMG Communication Skills' Training in Victoria's Public Hospitals

Background: This project is a descriptive study which scopes the provision of training programs for junior doctors in Victorian public hospitals, including communication skills' training specifically for international medical graduates (IMGs) working under supervision. There is no comprehensive overview of the nature, availability or uptake of communication skills training for IMGs in Victoria, particularly in rural Victoria where many IMGs are employed in public hospitals. As the literature suggests that some IMG doctors can struggle with aspects of clinical communication, an overview of training provision is warranted.

The aim of this project is to provide a comprehensive overview of IMG training provided in Victoria's public hospitals to determine the nature and extent of communication skills' training for IMGs and to identify gaps or issues that need to be addressed to improve IMGs' learning experiences and learning outcomes.

Methods: This scoping study, involves semi-structured interviews with providers of medical education, i.e. Medical Education Officers (MEOs) and Medical Clinical Educators (MCEs), to identify gaps and issues from their perspectives. The interview responses are collated and analysed thematically.

Findings: A key concern for hospitals is to ensure they meet their objectives in providing high quality health care to the community. Some of the health communication literature highlights a strong correlation between doctor-patient communication, patient satisfaction and improved patient health outcomes. This study will provide information about how well educators are meeting IMG communication training needs and will provide a basis for further research into other education and training models for IMGs.

Johannes H. Österholm & Lars-Christer Hydén

Department of Medical and Health Sciences, Centre for Dementia Research (Ceder), Division of Health and Society, Linköping University, Sweden

Representing needs in assessment meetings: Persons with dementia applying for formal supportive services

Aim: Dementia is a degenerative disease that affects the communicative abilities. When persons with dementia (PWD) apply for supportive services they must undergo a need assessment process often together with a relative. Central to this is the assessment meeting where needs and entitlement to support are negotiated. The purpose of this study was to investigate how and by whom the PWD needs and wishes was presented and negotiated.

Methods: The study is based on audio-recorded data from 11 assessment meetings in two Swedish municipalities, with relatives present in 10 of them.

Findings: The analysis of the meetings showed that one group of PWD was able to present and negotiate their own needs and wishes for supportive services; another group had severe problems negotiating their needs due to communicative problems. In these cases relatives took greater part in the conversation and presented both the PWD's and their own needs and wishes for support. Negotiation for different services – both wished and alternative services – was first and foremost conducted by the care manager and relatives. If services were agreed on the PWD was informed about the decision.

Implications: The result of this study shows the complexity to meet integrity and self-determination when entitlement to supportive services is assessed. Implications for communicative strategies to involve the PWD in the decision-making process are discussed.

Susan Philip, Robyn Woodward-Kron & Elizabeth Manias

The University of Melbourne

Intercultural communication in nursing: experiences and training needs of overseas qualified nurses (OQNs) in Australian health care

Introduction: Overseas Qualified Nurses (OQNs) are a significant part of Australia's health workforce. Twenty-seven percent of the Australian nursing workforce were born overseas and a large proportion of nurses are from Non-English Speaking Background (NESB) countries such as China, India, Philippines and Malaysia[1]. Research on the migrant nursing workforce has identified communication skills as an area that can impede these nurses' effective transition into the Australian workforce: poor communication skills can contribute to compromised patient safety and desired patient outcomes as well as disempowerment for the migrant nurses. To date there is no comprehensive exploration of the intercultural communication training needs of OQNs in Australia. This study investigates the communication experiences and training needs of OQNs in Australia.

Methods: This qualitative study adopts an ethnographic framework to explore the intercultural communication experiences and specific communication training needs of the OQNs participating in an accredited bridging program for hospital registration in Victoria, Australia. In the first phase of this study, educators in the ten bridging programs were interviewed on the scope of the communication skills training, as well as educators' perspectives on OQNs communication needs as well as intercultural communication challenges.

Findings and Implications: The findings will inform the design of the larger study, as well as provide a communication skills training snapshot of OQNs' preparation for the Australian workforce. Identifying specific communication skills needs in inter-professional, intra-professional and nurse-patient interactions as well as empowerment strategies for effective communication will assist these nurses in their transition to Australian healthcare.

1. Australian Bureau of Statistics (ABS) 2006, Selected Health Occupations: Australia; 2006 [updated 16 July 2008; cited 10

January 2013]. Available from: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4819.0

Thursday July 11th

2:00-3:55pm

Friday July 12th

10:30-12:55am

- Each presenter will present their topic for 10 minutes followed by a 10 minute discussion

Harriet Etheredge, Claire Penn & Jennifer Watermeyer

Health Communication Research Unit, School of Human and Community Development, University of the Witwatersrand, Johannesburg, South Africa

Interprofessional communication and organ transplantation in South Africa

Summary of content to be presented:

South Africa is a unique country in which to study health communication. Language and literary differences, asymmetrical power relations and other socio-economic factors affect access to healthcare, health outcomes and communication.

Initial thematic analysis of 15 – 20 in-depth interviews with transplant professionals from two South African hospitals (one state sector, one private sector) will be presented. The analysis will focus on interprofessional and patient communication in the process of organ transplantation. The presentation will be contextualized within a framework of multiple aspects effecting communication in transplantation. These include cultural, religious, language and time factors and the specific multidisciplinary communication required in the South African context.

Relevance to communication, medicine and ethics: The interviews presented are related to health professionals' perceptions on interprofessional communication and communication with patients and families regarding transplantation. Due to the number of different healthcare and other (social worker, religious leader) professionals involved, the interactions are complex. The ethical issues posed by communication in organ transplantation range from cultural and language factors to issues like informed consent, family consent, maintaining confidentiality of donor / recipient identity, financial issues, coercion / autonomy and ownership of the body.

Goals for roundtable discussion:

- To provide a perspective from a developing country on complex communication issues in organ transplantation

- To engage about interprofessional communication and its importance for ethically sensitive practice

- To gauge the opinions of other researchers in the field of communication about the analysis, themes selected and their appropriateness

Matthew Grant, Jenny Philip, Mark Boughey & Platon Vafiadis

Centre for Palliative Care, St Vincent's Hospital

Exploring community attitudes and beliefs regarding morphine usage in patients with cancer

Morphine is a commonly used medication that evokes a wide range of responses and attitudes. It is often associated with end of life care, and through this carries an array of preconceptions. The exact nature of these attitudes is not well documented in the literature. Participants will be adults, who may or may not have had experience or understanding of morphine use in a cancer setting, and come from culturally diverse outer Melbourne.

The project aims to explore the perceptions, attitudes and beliefs in the general community surrounding the use of morphine in patients with cancer. It will focus on the role that culture and spirituality might determine this understanding, and how any possible experiences of the participants might have challenged these opinions.

The outcome of this study is to determine which factors should be taken into consideration by nursing and medical staff when discussing the use of morphine, to improve patient and family outcomes. It is also planned to formulate a tool which may be used to evaluate these attitudes in a quantitative framework.

Goals for roundtable discussion:

The project is very clinically based at present, however I aim to further explore the ethical realm in greater detail. Presenting to a broad spectrum of professionals will hopefully lead to further insights and areas of discussion which had not been considered. As the project is based on grounded theory, there is the possibility to adapt aspects according to what has been found thus far.

Amy Hiller

The University of Melbourne

Considering the role of communication models in client-professional encounters: a physiotherapy perspective

Patient-centred care, the biopsychosocial approach and other communication models provide a framework for client-professional encounters. This session will utilize preliminary observation and interview data from a private practice physiotherapy setting to examine which features of these established models are enacted in patient-physiotherapist encounters. These communication models are often referred to in physiotherapy literature and education forums, but when specifically examined, there is a lack of empirical research evidence for their description and implementation. This gap in knowledge has prompted my enquiry as to the relevance of these models in physiotherapy practice, and whether and how they provide practical guidance in clinical encounters. My research is, in part, exploring this potential gap between theoretical models and the practice of communication in patient-physiotherapist encounters. I am seeking to utilize this forum to discuss and share ideas with other academics and researchers who have an interest in the role of communication models in guiding professional communication and interactions. This is an important topic which incorporates aspects of communication and relates to values in medical professional practice.

Goals for roundtable discussion:

- To promote discussion and interest in communication models pertaining to client-professional healthcare encounters, in particular how they inform every day healthcare communication;

- To examine whether there is a gap between the theory of communication models and communication enacted in client-professional encounters, and to discuss why this might be so;

- 3) To consider how communication models can be optimally integrated into communication in professional practice.

Kimberley Ivory

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How can we improve our understanding and management of ethical issues in community engaged patient-partnership programs?

Summary of content to be presented:

In their evaluation of the student experience of the Harvard Medical School–Cambridge Integrated Clerkship, Ogur and Hirsch (2009) analysed student narratives describing "the ways in which the longitudinal care of patients had influenced their learning." This analysis demonstrated that students participating in longitudinal patient care enjoyed "significant advantages for learning and professional development."

However, it also highlighted some important ethical questions inherent in such programs that require further analysis, such as:

- What is the role of the student: observer, advocate, companion?
- How do we prepare students and patients to negotiate professional boundaries and challenging situations?
- If the relationship is therapeutic, how is it, and how is that managed?
- What do patient-partners really think they are consenting to?
- How do we manage the end of the relationship?

The Sydney Medical School's Integrated Population Medicine program is a longitudinal community engaged patient-partner program. Initial evaluation of patients involved in the program suggest patients find participation an important and positive experience and are keen to be more involved. Student evaluations, however, suggest some anxieties and a disconnect between the student and patient experience.

Goals for roundtable discussion:

- I would like to discuss methods for teasing out students and patients' attitudes to these ethical issues. Potential data sources are students' reflective narratives of their meetings with patients, survey data from our evaluation, focus group discussions with students and

patients, and input from other medical schools with similar programs.

- My aim is to connect with others interested in increasing our understanding and deployment of community engaged patient-partnerships in health professional education in the Australian context.

Ogur, B. and D. Hirsh (2009). "Learning Through Longitudinal Patient Care-Narratives From the Harvard Medical School-Cambridge Integrated Clerkship." Academic Medicine 84(7): 844-850

Michael McKeon

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Physical activity of men with intellectual disability

The WHO (2009) and the United States Department of Health and Human Services (2002) identified physical activity as a preventative health measure and reported that physical activity is fundamental to preventing disease and is critically important for the health and wellbeing of people of all ages. Evidence from a number of studies on physical activity in people with intellectual disability indicates significant inactivity and associated behaviour risks to health for the majority of this population (Moss 2009, Temple and Stanish 2009). A review of literature on physical activity in people with intellectual disability found physical activity to be beneficial to their health and to lead to an improvement in their overall quality of life (Carmeli et al 2009, Lynnes et al 2009). Studies by Yalon-Chamovitz & Weiss (2008) and Temple (2009) highlighted that when providing personal and social support and motivation in physical activities for people with intellectual disability there is a marked improvement in levels of activity, which reduce health risks and enhance their quality of life. The aim of the paper/presentation is to consider physical activity undertaken by men with intellectual disability and present it in any one of the three categories colloquia, paper presentations (oral or poster) or (3) works in progress for roundtable discussion.

Goals for roundtable discussion:

• To describe a survey of physical activity for men with intellectual disability
• To describe the research ethics involved in the study
• To outline the pilot study completed
• To describe the client professional encounter and communication characteristics of the study

CARMELI, E., BARAK, S., MORAD, M. and KODESH, E., 2009. Physical exercises can reduce anxiety and improve quality of life among

adults with intellectual disability. International SportMed Journal, 10(2), 77-85.

LYNNES, M.D., NICHOLS, D. and TEMPLE, V.A., 2009. Fostering independence in health-promoting exercise. Journal of Intellectual Disabilities, 13(2), 143-159.

MOSS, S.J., 2009. Changes in coronary heart disease risk profile of adults with intellectual disabilities following a physical activity intervention. Journal of Intellectual Disability Research, 53(8), 735-744.

TEMPLE, V.A., 2009. Factors associated with high levels of physical activity among adults with intellectual disability. International Journal of Rehabilitation Research, 32(1), 89-92.

TEMPLE, V.A. and STANISH, H.I., 2009. Pedometer-measured physical activity of adults with intellectual disability: predicting weekly step counts. American Journal on Intellectual & Developmental Disabilities, 114(1), 15-22.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2002. Physical Activity Fundamental to Preventing Disease. Atlanta, GA: U.S. Department of Health and Human Services.

World Health Organization, 2009. Physical Activity. (http://www.who.int/dietphysicalactivity/pa/en/index.html) Access 28/01/10

YALON-CHAMOVITZ, S. and WEISS, P.L., 2008. Virtual reality as a leisure activity for young adults with physical and intellectual disabilities. Research in developmental disabilities, 29(3), 273-287.

Maria Stubbe, Lindsay Macdonald, Ben Gray, Jo Hilder, Rachel Tester & Tony Dowell

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Negotiating role boundaries in interpreter-mediated consultations

Background:

In New Zealand, cross-cultural health encounters are increasingly common, and interpreters are increasingly used where the patient has inadequate English to get optimal care. However, use of informal/untrained interpreters (or no interpreter) remains very common, and GPs often have limited knowledge or training in this area. Moreover, little is known about the impact of current practices on how interpreted consultations are carried out, and how effective such consultations are from the perspectives of all participants. This work-in-progress paper will present initial findings and illustrative data excerpts relating to one analytic theme from a current study set up to explore these issues. To date the research team has collected video-recordings of 12 interpreted consultations along with post-consultation interviews with all participants. The data includes a variety of interpreting 'models', including professional interpreters (independent and employed by the practice), bilingual health professionals, and informal interpreters (family or community members).

Findings to date/Goals for roundtable discussion: Our initial analysis of the interview and consultation data indicates that even where participants clearly articulate what they see as the role of the interpreter, when we closely observe the unfolding interaction, role boundaries are in fact continually being negotiated and re-negotiated along with sometimes competing interactional, interpersonal and cultural imperatives. Participants can also be observed to use a range of discursive strategies to manage such shifts. These tensions and complexities in the 'interpreter' role merit further consideration, and we would welcome a roundtable discussion of the implications of our observations to date.

Margo Turnbull

University of Technology, Sydney

An archaeology of the primary health care patient: an examination of public and private identity

Summary of content to be presented:

Since the Alma Ata in 1978 primary health care has been a focus of international reform and investment (Bryant & Richmond, 2008). The Australian primary health care system is struggling with the demands of an ageing population, increases in chronic health conditions and spiralling costs (Bonney, Magee & Pearson, 2012). Policy and public discourses claim that the Australian primary health care system must show radical improvements in efficiency and cost effectiveness to remain viable.

Contemporary discourse has created a public identity of the health consumer – a patient who is likely to live to a greater age, use up scarce health resources, develop avoidable 'life-style' related diseases and require additional support to take responsibility for their health. Limited research has been undertaken to uncover the private, or self-identity, of these patients. The archaeology to which the title refers is the process of articulating an identity of 'the patient' as it is defined by contemporary public discourse and comparing this to the private identity as constructed by the patient. The content to be presented at the roundtable discussion will include patient narratives collected from research subjects in two health districts in Western Sydney that are the focus of a broader ARC-funded project looking at the remaking of practices in primary health care. This data will be supplemented by early stage analysis of a selection of the public discourses that are creating the identity of the contemporary, Australian primary health care patient.

How topic relates to communication, medicine & ethics:

The current discourses shaping primary health care in Australia influence the way in which practitioners communicate with patients and way services are designed. Effective communication is key to responsive and

appropriate health care and thus improved understanding of these discourses is essential.

Goals for roundtable presentation:

- To increase understanding of the ways and points at which a patient's private identity influences their health behaviours and use of health services

- To share ideas for methods of collection of patient narratives and innovative approaches to 'user involvement'

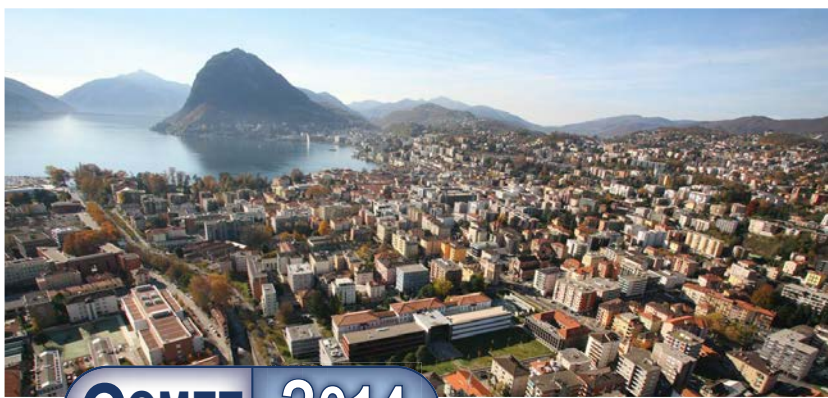- To link with other complementary studies/researchers.

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