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VERDIS: Video-based communication research and training in decision-making in supportive and palliative care

Principal Investigator:

Dr Ruth Parry, Senior Research Fellow, Sue Ryder Centre for the Study of Supportive, Palliative and End of Life Care, School of Health Sciences, University of Nottingham, B Floor, Queen's Medical Centre, Nottingham, NG7 2HA. Email: ruth.parry@nottingham.ac.uk Phone: 0115 823 0873

Co-investigators:

Dr Marco Pino[1]; Prof. Jane Seymour[2];, Dr Christina Faull[3]; Dr Luke Feathers[3]; Kerry Blankley[4]; Joe Ford[5] ; Dr Alexa Hepburn[5]; Dr Victoria Land[6]; Dr Laura Jenkins[6]; Ms Becky Whittaker[2*]

1. Marie Curie Research Fellow, Dept of Social Sciences, Loughborough University, Ashby Rd, Loughborough, LE11 3TU (formerly at the University of Nottingham)
2. Sue Ryder Care Professor of Palliative and End of Life Studies, School of Health Sciences, The University of Nottingham
3. Consultant in Palliative Medicine, LOROS Hospice, Groby Rd, Leicester, LE3 9QE.
4. Education Facilitator, LOROS Hospice, Groby Rd, Leicester, LE3 9QE.
5. PhD student, Dept of Social Sciences, Loughborough University, Ashby Rd, Loughborough, LE11 3TU
6. Research Fellow, Sue Ryder Centre for the Study of Supportive, Palliative and End of Life Care,School of Health Sciences, The University of Nottingham

*Ms Whittaker undertook the evaluation of REAL TALK.

Report prepared by Prof. Jane Seymour, on behalf of the project team

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1. BACKGROUND

High quality staff-patient communication is central to compassionate, effective healthcare. There has been limited progress towards generating robust evidence about the precise structure and functioning of healthcare communication. This impedes development of effective interventions and their evaluation. Conversation analysis, which relies on audio- and video-recordings of naturally occurring healthcare episodes is making rapid advances, particularly in generating evidence about communication in primary care medicine. The conversation analytic approach was used in this study to generate underpinning knowledge about the structures and functioning of healthcare communication behaviours in specialist palliative care, and to design associated staff communication skills training materials.

In this study, we focused on communication in specialist palliative care provided in a hospice. Good communication is central to high quality effective care for people nearing the end of life and their friends and relatives [1, 2]. Poor communication is associated with distress and complaints [3, 4]. Also, we know that one particular element of communication in this domain - discussing and making plans and decisions about future care - influences place of death, and aggressiveness of care [5, 6], but little is known about *precisely how* staff can support patients to engage with such sensitive, challenging discussions, and about how to do so in an empathic manner. Thus we studied decision-making communication and communication associated with empathy – a quality highly valued by patients and their companions [7]. We know that patients and professionals are reluctant to address sensitive issues and decisions about the future and that practitioners' uncertainty about *how* to talk with patients and family members about these is an important obstacle [8]. In an international survey of 90 palliative care experts, 80% wanted more evidence-based guidance on optimal communication strategies to improve decision-making practice [9].

There is already an established communication skills training programme for healthcare professionals – the 'Connected' advanced communication skills training programme, which is based within regional cancer networks, and funded through local commissioning [10, 11]. This kind of training is primarily delivered to staff who work in oncology and specialist palliative care. Systematic reviews indicate these courses have some positive effects [3], but that these are confined to two particular behaviours: trainees' expression of empathy and question-asking behaviours. Unfortunately, no benefits have been shown in terms of patients' communication behaviours and their perceptions of communication quality; also evidence about long-term effectiveness is contradictory [3]. Furthermore, current training is based upon limited evidence: little derives from direct observations [10], and most is specific to cancer patients [11]. There is good reason to anticipate stronger effects were it grounded in more detailed evidence about communication behaviours and skills [10, 12-14]. This study aimed to generate such detailed evidence, with data and analysis not solely confined to discussions with people with cancer.

Video-based research on communication is relatively new within healthcare research, but is already developing a track record of yielding useful findings, for instance, it has identified specific communication practices that enhance patient satisfaction [15], and that increase vaccine uptake rates [16]. Video-based conversation analytic research has also led to design of communication training and interventions that have been shown to be effective in improving healthcare consultations – for instance in enabling primary care patients to express more of their concerns within consultations with doctors [12], and people attending HIV clinics to express their concerns more succinctly and readily [17]. Thus we know that video-based research on recordings of 'real' patients and professionals yields benefits to patients. However, it is not yet known whether using video-recordings of 'real' rather than simulated interactions in communication training increases its effectiveness and thus leads

to improvements in staff-patient communication; we will address this important question within the research programme of which the current study forms part.

In this study we sought to generate evidence about how experienced, specialist hospice doctors communicate with patients and their accompanying friends/relatives, and design staff communication training materials aiming to pass on those skills to less experienced, less specialist staff. The resultant materials include video-clips of real interactions (where all participants permitted this use of their recordings); these were piloted in communication skills training at 11 sites and a preliminary evaluation conducted on trainees' and trainers' perspectives on perceived value, acceptability and usability.

2. STUDY OBJECTIVES AND PURPOSE

2.1 PURPOSE

- To produce detailed knowledge about the structure and functioning of communication practices and strategies which:
    a) provide opportunities for and implement shared decision-making

    and/or

    b) are associated with empathy

  and that occur during discussions between experienced hospice doctors and their patients (and accompanying friends / relatives)

- To use the findings to design staff training materials and prepare for large-scale evaluation of the effects of such video-supported training

2.2 OBJECTIVES

1. To make and analyse, using the conversation analysis approach, up to 45 recordings of interactions between experienced hospice doctors (up to 10) and patients (up to 45, with a maximum number of 3 consultations for each patient) and accompanying friends or relatives (up to 45)
2. To document the structure and functioning of communication practices associated with empathy and with providing opportunities for and implementing collaborative decision-making
3. To design and develop associated materials on communication in end-of-life care which include scripts, video-clips, and teaching points, based on the findings, and designed for use in face-to-face staff communication skills training
4. To pilot these communication training materials and evaluate usability and acceptability (REAL TALK evaluation).

3. METHODS

3.1 STAKEHOLDER INFORMED DESIGN OF STUDY PROCEDURES

There is limited guidance on ethical and effective practice in video-based healthcare research. In preliminary work, we undertook a review of the literature, and conducted a stakeholder consultation with palliative care patients, their relatives, and staff. These consultations shaped the design of procedures for our study. Our study design, including in

the procedures for recruitment, consent, data storage and use, complied in full with guidance provided by the General Medical Council (on making and using visual and audio recordings of patients, including for the purposes of research) [18] , and drew extensively on advice and guidance from other publications, including from the National Centre for Research Methods and the ESRC (in a working paper focused on video-research in educational contexts) [19], the European Union (in a guidance note for researchers and evaluators of social sciences and humanities research) [20] , and from publications recording experiences and recommendations arising from video-based research in older people's care [21] day hospice settings [22] and resuscitation in high risk obstetric deliveries [23].

Appendix 1 provides a paper under review by *Patient Education and Counselling* providing guidance about video recording in health care settings which resulted from these activities, entitled *'Acceptability, feasibility and design of video-based research on healthcare communication: evidence and recommendations'*.

3.2 STUDY CONFIGURATION

Single centre: a hospice which delivers in patient, day therapy, and outpatient care.

Video and audio research: entailing recording and analysing consultations / conversations involving up to 10 palliative care doctors and up to 45 patients (and their companions where present). The aim was to capture what would go on whether or not recording were taking place – that is, only consultations that would be occurring whether or not the study were taking place were recorded.

A brief ten-item post-consultation questionnaire: completed by participating, consenting patients.

User-centred design and the conversation analysis role play method was used to design staff communication training resources (REAL TALK) which were housed on a password protected DVD kept in the trainers' possession, or a password-protected online repository – with passwords known only by the trainers and the researchers. These materials were only used by registered, professional communication skills trainers within face-to-face staff communication skills training.

3.3 STUDY MANAGEMENT GROUP:

The management group comprising the research team met at three monthly intervals throughout the study to monitor and discuss progress.

3.4 STUDY ADVISORY GROUP

An advisory group was established to advise on design, ethical and methodological issues. It comprised a senior US academic leading video-research in oncology settings, an experienced communication skills trainer who delivers training within the national 'Connected' training programme mentioned above, a lay representative who is a member of the LOROS Hospice's Patient and Carer representative group, and the award manager from our funder - the Health Foundation. The advisory group met with the research team four times over the two year project to review progress and the achievement of project milestones.

3.5 ETHICAL APPROVAL AND PORTFOLIO ADOPTION

Ethical approval was obtained from a local research ethics committee (NRES Committee West Midlands - Coventry & Warwickshire, ref 14/WM/0128) and the study was adopted onto the UK Clinical Network Study Portfolio (UKCRN id: 17400).

3.6 SUMMARY OF DATA COLLECTION: PATIENT DATA

Patients presenting for inpatient, outpatient, or day therapy consultations with one participating doctor in the hospice were asked to participate in our study if they had capacity to consent, were able to speak and understand English, and were judged by the care team not to be in acute distress. All patients had a terminal diagnosis and had been referred to the hospice for symptom management.

Before recording, the researcher provided information about the study purpose and processes, and sought verbal assent to record their conversation with the doctor. At least one day after recording, written informed consent was sought from the patient and any companion present.

3.7 'REAL TALK' EVALUATION: SUMMARY OF OBJECTIVES AND METHODS

3.7.1 OBJECTIVES

- To gather information from Real Talk resource users which will inform additions to and revisions of the existing Real Talk resource
- To gather information from Real Talk users, both trainers and trainees to inform design of future training resources centred around recordings of real life practice with allied health professionals;
- To evaluate Real Talk in terms of its usability and acceptability from the perspective of trainers and trainees by observing some events in which the resources are used, and seeking views and perspectives via brief anonymous questionnaire survey with trainees, and qualitative interviews with trainers

3.7.2 METHODS

Trainers volunteered to take part in response to announcements at special interest group meetings and workshops, and to invitations in newsletter articles. They are geographically widespread across England, Scotland and Wales.

Trainers participated in a qualitative, semi-structured interview, mostly over the telephone. This took place after they have tried out the Real Talk resource in an actual training event. Interviews were audio-recorded, verbatim transcribed, and analysed using qualitative, thematic analysis.

A subset of volunteer trainers were observed in situ, using the Real Talk training resource during a training event. Time and cost constraints meant we could not observe all trainers. As far as possible, observed events and trainers included a wide a spread of participants as possible from HEI's to NHS settings and voluntary organisations. Trainers piloted the Real Talk resource within their usual work, i.e. in delivering face to face healthcare communication skills training.

Views of trainees were sought by completion of the short 4 part questionnaire that was completed immediately at the end of the training sessions and either handed back to the trainer or posted to the research team.

4. KEY FINDINGS

4.1 RECRUITMENT AND RECORDINGS

By the end of December 2014, we had recorded 37 consultations involving 37 patients, 17 accompanying family members/friends, and 5 doctors. The consultations are between fifteen minutes and one hour and fifteen minutes long. One patient opted to be audio rather than video recorded. Several patients opted to withdraw from the study after recording – their recordings were deleted.

4.2 DATA ANALYSIS OF RECORDINGS

This is in progress. Foci are: how end of life is broached (as a preparatory step to making plans and decisions for future care); advance care planning; negotiation when patient and doctor preferences differ; empathy; pain and pain medications. Joe Ford University of Loughborough) is looking specifically in his linked doctoral project at doctors' use of empathic talk in the recordings. Victoria Land is examining shared decision-making, with the latter informed by a systematic review of the evidence from conversational analytical research around shared decision-making in health care (in preparation) by Parry and Land. Laura Jenkins is examining talk about pain; a progress report on this aspect is in **Appendix 2.**

Appendix 3 provides a draft paper (submitted for review) showing- from a detailed conversational analysis of recordings- how experienced palliative care doctors engaged patients and their companions in end of life talk, with a particular focus on whether doctors observably treated patients/ companions talk as 'cues' to end of life concerns and how they then elicited further talk about the issue at hand. We show that doctors use 'open elaboration solicitations' to create opportunities for the patients to volunteer end of life considerations. This allows the doctors to navigate a core dilemma in the promotion of end of life talk: giving patients opportunities to engage in conversations about end of life whilst displaying sensitivity to patients' communication needs and preferences.

4.3 REAL TALK TRAINING RESOURCE

The communication training resource ('Real Talk') has been designed and built and comprises a DVD and trainers' handbook. Real Talk is novel because at its core are extracts from video and audio recordings of actual, everyday supportive and palliative care consultations made as part of the VERDIS study. Currently, palliative and end of life care communication training often includes work with recordings of communication episodes which involve actors playing the part of patients and relatives – i.e. these are role-played, not authentic communication episodes. Trainers and trainees frequently report trainee dissatisfaction with these resources, and recent empirical research shows that simulated interactions differ importantly from real life ones.

The Real Talk resource was designed for use within communication skills events already regularly delivered to staff and students. It offers additional resources that can be added to and slotted into existing ways of working; it is not a standalone course.

4.3.1 REAL TALK PILOT PARTICIPANTS

Following the period of publicity seeking expressions of interest regarding the pilot, 44 experienced communication skills trainers requested a copy of the Real Talk DVD. This represented 12 hospices, 13 NHS trusts and 8 Higher Education Institutes.

4.3.2 SAFEGUARDS

On receipt of the DVD all 44 trainers signed and returned a DVD receipt form. This indicated agreement as follows:

- DVD resource only to be used for communication skills training;
- Only to be used by named trainer(s);
- Copyright© University of Nottingham, 2015. All rights reserved. Not to be reproduced in whole or in part without the permission of the copyright owners.

All trainers working within the NHS, HEIs or the voluntary sector may keep and continue to use the DVD as long as the safeguards below are introduced at the start of each training event:

- These materials include content that can be distressing, feel free to step out of the session if this is the case for you;
- In your own working or personal life you could come across people you see in the clips. Be aware that they are unlikely to know that you have seen them in this way;
- Both during and after the session please do not talk about any individual in personal or negative terms, and if you recognise them please do not refer to them by their real name;
- No one in the recordings is claiming that their practice is perfect, but the clips do include skills and actions that contribute to good practice;
- You must not take any visual images or make audio or video recordings of the clips when they are playing;
- All the people you will see and hear gave their permission for the use of their recordings in training sessions provided these safeguards are in place.

4.3.3 DATA COLLECTION

Data was collected in three ways:

i) Observation of a range of training events where Real Talk was incorporated into an existing timetable.
ii) Interviewing, face-to-face or via phone the trainer facilitating the use of Real Talk.
iii) Questionnaires completed by trainees immediately at the end of the training event.

4.3.4 RESULTS

During the pilot period 1 July to 30 November 2015, 15 trainers went on to provide data. This represented 6 hospices; 5 universities; 2 hospital trusts. Organisations providing data for the pilot included the following:

Hospices: Hayward House, Nottingham; John Eastwood, Mansfield; LOROS, Leicester; Rowcroft, Torquay; St Christopher's, London; Wirral St Johns, The Wirral;

HEIs: Bradford; Cambridge; East Anglia; Nottingham; Worcester;

NHS Organisations: Derbyshire Community Health Services; Nottingham City NHS Trust.

Those who did not use Real Talk were either not providing training during the pilot period or trainers felt it was not appropriate for their student groups. Feedback from NHS trusts to establish why more trainers did not pilot the tool suggests this was mostly due to i) time restrictions to review the resources as most facilitators were also senior clinicians, ii) planned training being cancelled or iii) training not planned during the pilot period.

A total of 10 training events were observed, with 11 interviews completed with trainers. A total of 150 questionnaires were returned by trainees.

4.3.5 USABILITY AND ACCEPTABILITY OF REAL TALK

The resource was overwhelmingly welcomed by both trainers and trainees as an effective and safe tool to use in communication skills training, adding depth and value to the learning experience. Key themes emerging from the data with regards to the usability and acceptability of the Real Talk clips relate to its overall value of 'realness', the importance of skilled facilitation, the value of group discussions, the role of emotion in learning.

> *"…I think its streets ahead, to be honest. Absolutely a street ahead, the reason being is that it is, as the title says, it's so real. It's humbling. Every time you watch it, it affects you differently…"* [R10]

VALUE OF REALNESS

There was a strong message in all the evaluation data relating to the value of using 'real' film clips. This moves the resource beyond being merely 'acceptable' to potentially being a significant resource to enhance the learning experience in communication skills training.

> *"…because I think an awful lot of pressure is put on.. professionals, to think they've got to get it right first time, every time, without fail, and I think that clip* [Eashan] *really illustrates the fact that, actually, you know, the bottom line is, we're all human and these are difficult discussions, and they will always remain difficult discussions but if we can bring the humanity into it, then, then, you know, you can't go far wrong, really…"* [R11]
>
> *It's good to watch real situations as in everyday (working life) you don't get that opportunity Somethings I feel I do already but don't always realise and it's good to see what works well [Q38]*
>
> *Reality - is real [Q32]*
>
> *To see a true account of the real life patients dealing with their prognosis/life/treatments and mentally / acceptance of dying compared to actors* [Q43]
>
> *Very useful. Very good to witness real life conversations rather than role play. Good to discuss strategies/techniques* [Q144]

An overall theme emerging from the data was how the trainers recognised the value of working with the real clips to explore 'what did you see?' rather than 'what did you think?' This approach resulted in an exploration as skills based 'process' rather than a focus on 'outcome'.

> *The topic was unavoidably difficult. I found the recordings helpful to get in touch with these experiences and prompt reflection in working practice* [Q147]

Trainees actively engaged in discussion, more so than expected by the trainer. Trainees linked the Lucy clip to their own experiences of working with patients at very end of life. Also realised that it could be used for much more fundamental teaching relating for example to empathy, compassion and care [O1]

Trainers noted a depth to discussions association with Real Talk that they had not experienced in role play or using other resources. These discussions had the power to move beyond communication skills to wider subjects including empathy, establishing a relationship, and concepts of caring and compassion.

…Well, they started off observing communication skills and kept it very much on that level. And then as the clips unfolded, they started to talk about more general palliative care themes and we talked about involving family members, so when we watched Eashan and his brother, we then started talking about involving family members. We went on to have a discussion about person-centred care planning… [R1]

…We have used it about 6 times and it's definitely growing on us, as we become more familiar with it, the results and impact have been really good. The attendees are really engaging in it and this week was probably the best, with the impact of the real consultations adding much more depth and importance to them wanting to get the "simple things" right like active listening, clarifying, patient lead agenda etc... [T10]

…Well it would fit into something much more fundamental – like use in empathy and compassion teaching. That is all so important and it is really underpinned by communication skills. [R4]

SKILLED FACILITATION

Trainers using Real Talk have demonstrated the importance of being skilled and confident in facilitating group discussion relating to sensitive materials.

…Because it was, because it was a first time I used it, I, I didn't feel confident enough to stop and start, because I didn't feel I knew the vignettes well enough. I feel that once, if I used it again and again, you know, next course, for example, and the course after that, and got to know the clips, got the know the material, if you like, I would feel confident to say I'm going to stop there and we'll talk about what just happened there… [R2]

…It always surprises me in communication skills, you know, that sort of, trust your audience mantra … I always find that a little bit unnerving. But it worked really well, they were superb…'[R9]

Trainers involved in the pilot worked with the clips to facilitate exploration of understanding relating to 'process' rather than 'outcome'. This required expert facilitation to move trainees away from saying what they would do differently in each scenario, or what wasn't done, to a more focussed and in-depth exploration of the communication interaction and skills involved. Trainers seemed to both value this and recognise the value of working with uncomfortable materials.

Data also indicated that skilled facilitation was essential to add value and ensure safety to the learning experience, this links to recognising the emotions the clips and associated discussions can invoke. There is limited evidence on whether trainers used Real Talk differently from other communication skills resources, however it was noted that trainers

liked the ability to work with short clips of film to enable trainees to focus down on process issues that could be used independently from the other clips in the scenario.

> *…it's very bitesize. … But it's very powerful and that's amazing really…* [R9]

> *…And it helped to sort of go back to the start of the clip or to part of the clip and just, again, it's using it to make it cement, I suppose, some of the things from earlier…* [R3]

> *…the lovely thing about the Eashan clip was that it covered so much, it was fantastic…* [R11]

Trainers mostly used the clips to consolidate prior learning, emphasise a specific skills or to engage in group discussions resulting in an absence of data with regards to the use of the clips to frame role play between trainees. However facilitators overwhelmingly suggested that Real Talk can be used alongside role play rather than replacing it.

EMOTION AND CONCERNS

There were no specific elements of the Real Talk materials that caused distress, or other negative responses sufficient to be disruptive to teaching and learning. There appears to be an inherent link between the skilled facilitation and managing emotion.

> *Yes, we do get emotional responses from, you know, the candidates that they come in, but they then will come back, they'll choose to stay, to watch it, even, you know, when some of them have absolutely been quite upset, and then they come back to us after and they've said to us, Do you know, that's what I needed. Its almost, its cathartic…* [R10]

The 'Lucy' clip appeared to be the cause of most distress, though one trainer noted that the depth of discussion that this conversation led to with regards to practitioner mortality, and importance of self-care.

> *…I was struck at how engaged the group were, particularly with Lucy clip and how they picked up on the words she used. I wasn't expecting that discussion about the grim reaper and the debate that resulted from it, particularly with students giving personal thoughts and not necessarily agreeing with each other…I was a bit worried as at one point I thought I was going to get upset myself. I was really taken with the power of how it made them feel and that it pulled out what dreadfully hard things nurses have to face on a daily basis…* [R4]

There were no other examples of distress recorded in the data sets. Of the 150 completed questionnaires, one trainee ticked 'no' to: 'If you were to attend a similar training event in the future, would you what it to include work with recordings of actual healthcare consultations? There was no written comment to expand this answer. This trainee indicated that learning had not been impacted on by the emotion raised. What was seen in the data overall was the value of emotion to the learning experience, from a personal reflective process as well as linking theory to skills in practice. Here is a selection of trainees' written comments:

- *Discussing the recording together really helped to acknowledge and talk through the emotions it evoked* [Q42]
- *Shows ability to empathise with patients through emotion [Q8]*
- *Yes emotional but this made me reflect on it well I feel [Q13]*
- *It was emotional but very useful [Q74]*

- *It was difficult to hear/watch but really enhanced my learning - made me think broader [Q53]*
- *Its emotionally upsetting but did not impact on my learning, mainly because it highlights what you do as health care professionals working in palliative care [Q43]*
- *Because they were not actors I was able to get a realistic sense of care and compassion given by health professionals [150]*

5. CONCLUSIONS

The strength of this study is that it recorded and analysed real interactions between doctors and terminally ill patients and then used these to inform communications skills training through development of an innovative resource 'REAL TALK'. One study limitation is that it only looked at a hospice setting with consultants with years of training and experience; additionally, the consultations analysed in this study lasted 48 minutes on average, which would be unusual in any other health care setting. The study only recruited patients who had capacity and speech, and who spoke and understood English; this does not cover the full spectrum of terminally ill patients. Despite these limitations we argue that the communication practices examined in this study are available for anyone to use and are therefore potentially transferable to other settings.

We have demonstrated through the pilot evaluation of Real Talk that the resource is regarded as acceptable and usable by a range of palliative and end of life care communications skills trainers and trainees. Its use is rapidly expanding nationally and we anticipate being able to gather further evaluative data regarding the resource over the coming year. We are undertaking further research funded by the NIHR in this field amongst allied health professionals, using a similar project design. We look forward to working with the research team and with clinical collaborators in developing follow on research to understand in more depth how Real Talk is used, how trainers and trainees can be supported to gain maximum value from it, and, most importantly, what the impact of the resource is on patient care as trainees transfer their learning to practice.

Understanding barriers and facilitators to transfer of learning is a key area of future research. Future research should additionally address how clinicians engage patients in EOL talk in different settings; how clinicians transition to planning for future care once the topic of dying has been raised in the conversation; whether some practices for engaging patients/ companions in EoL talk are more effective than others; and how patients/companions perceive EoL conversations and what they understand to have been communicated.

Publications/ presentations from the project are currently work in progress but we anticipate making a sustained and significant contribution to the field from this study and are grateful for the support of the Health Foundation in making the study possible.

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6. PUBLICATIONS AND PRESENTATIONS

6.1 CONFERENCE PRESENTATIONS

Pino M., et al (forthcoming) Promuovere conversazioni sul fine vita: Risultati e proposte da una ricerca sui temi della medicina palliativa svolta presso un hospice inglese [Promoting end of life conversations: findings and recommendations from a research project carried out in an English hospice]. *ANT Foundations (Italian National Tumour Assistance Foundation). Bologna, Italy.* 6th April 2016
Pino M., et al (forthcoming) Talking about dying: how palliative medicine doctors give patients and their companions opportunities to discuss end of life. *Communication, Culture and History Seminar Series. Department of Social Sciences, Loughborough University,* 17th Feb 2016
Pino M., et al(forthcoming) Talking about dying: how palliative medicine doctors give patients and their companions opportunities to discuss end of life. *Department of Lifelong Education, Administration, and Policy - The University of Georgia College of Education (via Adobe Connect).* 22nd February 2016
Pino M., et al (forthcoming) Contribution within the panel "Combining qualitative and quantitative approaches to analyse emotional talk in medical consultations". *European Association for Communication in Health Care, Heidelberg, Germany.* 7-10 September 2016
Parry R., Pino M., Land, V. Faull C. and Feathers L. (2015) Whose responsibility is it to initiate talk about death? *9th Loughborough CA day,* Loughborough University, UK. 14th December 2015,
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March 2014 Palliative Care Congress, UK national conference. *Views of hospice staff, patients and their significant others on video-recording consultations for use in research and teaching*

6.2 OTHER PRESENTATIONS AND SEMINARS

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Parry, R. and Pino, M. (2015). 'How do hospice doctors broach end-of-life matters in conversations with terminally ill patients?' *Sue Ryder Care Centre Research Group Seminar,* University of Nottingham, 26th march 2015
Ford, J. (2015) Empathy in palliative care consultations: Some preliminary observations. *3rd EMCA Doctoral Network Meeting*, University of Nottingham, 20-21 April 2015.
Parry R., Pino M., Faull C. and Feathers L. (2015) Knocking at the door or pushing it open: what conversation analysis tells us about how people talk about difficult issues such as illness progression and death. *Keele University Psychology school seminar series*
Pino, M., Parry, R., Faull, C., Feathers, L., Blankley, K. and Seymour, J. (2014). Views of hospice patients, their significant others and of staff, on video-recording consultations for use in research and teaching. *School of Health Sciences Seminar, University of Nottingham*, 18th June 2014.
Parry R., Pino M., Faull C. and Feathers L. (2014) Using recordings of real life doctor-patient conversations to understand and teach communication. A round up of current research, focusing on discussing difficult issues. *Norwich Medical School consultation skills seminar series*, University of East Anglia
Pino, M., Parry, R., Faull, C., Feathers, L., Blankley, K. and Seymour, J. (2014). Views of hospice patients, their significant others and of staff, on video-recording consultations for use in research and teaching. *School of Health Sciences Seminar, University of Nottingham*, 18th June 2014.
Pino, M. and Parry, R. (2014). Video-based communication research and training in decision-making in supportive and palliative care: preliminary findings from Phase 1. *LOROS hospice learning event,* Leicester. 27th February 2014.
October 2014. Invited presentation at Physiotherapy UK, the annual conference of the Chartered Society of Physiotherapy Getting communication right: Tales, tools and tips from communication science (incorporated data and analysis from the VERDIS study on decision making)
October 2014. Seminar with UK based healthcare communication researchers which we convened : Using conversation analysis to analyse healthcare decision-making – preliminary results of a systematic review, and data analysis session on recorded hospice consultation

6.3 POSTER PRESENTATIONS

Parry R., Pino M., Faull C., Feathers L., and Seymour J. (2015). Evidence-based guidance for designing video-based research. *The Society for Research in Rehabilitation Winter 2015 Meeting*, Manchester, 3rd February 2015.

Pino, M., Parry, R., Faull C., Feathers, L. and Seymour J. (2015). Talking about the end. *research Showcase*, 17th June 2015, The Univeristy of Nottingham, UK

6.4 WORKSHOPS

Winterburn, S. and Pino, M. (2015). Applying conversation analysis perspectives and methods to teaching end of life care. *EACH Summer Event*, 24-26 August, Regent's University, London, UK

6.5 PUBLICATIONS

Parry, R. Pino, M., Faull, C., and Feathers, L (under review) Acceptability, feasibility and design of video-based research on healthcare communication: evidence and recommendations. *Patient Education and Counseling.*

Pino, M., Parry, R., Land, V., Faull, C., Feathers, L., and Seymour, J. (to be submitted) Engaging terminally ill patients in end of life talk: How experienced palliative medicine doctors do it. *Plos one*

Parry, R. (2015) Patient-focused practice and communication: Use of communication in the clinical setting. In Jull, Moore et al (Eds) *Grieve's Modern Musculoskeletal Physiotherapy* 4th Edition

Parry, R., Land, V. and Seymour, J. (2014) How to communicate with patients about future illness progression and end of life: a systematic review. *BMJ Supportive and Palliative Care* 4(4): 331-41

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