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VERDIS

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Video-based communication research and training in decision-making and empathy in supportive and palliative care Newsletter 2014



VERDIS

What is the VERDIS study?
Find out more about the study.

VERDIS initial findings
What's happened so far.

In other communication research...
...medical interpreters.

What is VERDIS?



VERDIS is research aiming to improve knowledge and training about face to face communication between healthcare staff and terminally ill people and their significant others.

We intend to:

- Record healthcare conversations between experienced doctors and terminally ill people and their significant others
- Understand the communication capabilities involved
- Pass them on to other staff

We are focusing on how staff can involve patients and their significant others, particularly when making plans and decisions. We are also examining ways in which staff can sensitively deal with distress and other difficult emotions.

To do so, we are video-recording consultations between senior doctors and outpatients, day therapy patients, and inpatients at LOROS hospice. The recordings are being analysed using a scientific method called 'conversation analysis'. Clips from the recordings will be used by staff trainers who deliver communication skills training to qualified and trainee health and social care workers. The Health Foundation is funding the project.

The people working on the project are:



Ruth Parry and Marco Pino
Researchers from The University of Nottingham who specialise in video-based research on healthcare.



Jane Seymour
An experienced researcher at The University of Nottingham who researches palliative care.



Christina Faulk and Luke Feathers
Doctors from LOROS hospice who also do research and training in palliative care.



Alexa Hepburn
A researcher from Loughborough University who specialises in audio and video based research on language, and particularly on empathy and distress.



Kerry Blankley
An educator and nurse based at LOROS who runs communication skills training courses.



Joe Ford
PhD student at Loughborough University who is researching empathy and distress using the video recordings from VERDIS.

Is video-recording acceptable, and if so, how can it be done well?

Video-recording can be a highly valuable resource to understand doctor-patient communication in palliative care. Video recordings of real life consultations are also in demand for communication skills training. However, this means approaching people to ask them about being recorded at a time when they are particularly vulnerable.

To check whether our research would be acceptable, and help us design it with care, we conducted a 'stakeholder consultation'. We asked ten patients, five relatives, four nurses, seven doctors and five communication skills educators about their views. All thought the video-based research could be an acceptable and indeed very useful way of helping improve communication in this clinical area.

However, they also expressed several concerns, including:

- possible risks of recruiting patients and their significant others at a time where they are likely to be in a very fragile position
- whether presence of a camera would alter doctors' and patients' communication in a detrimental way
- loss of control over future uses of one's own image (including after a recorded person's death)

The people we spoke to also suggested safeguards which could help ensure the research was done in safe and respectful way.

We combined their suggestions with other recommendations from published guidelines (for instance from the General Medical Council). We then used these to design the VERDIS project.

We are preparing a research article about how best to go about video-based research in healthcare settings.

You can find out more at: www.nottingham.ac.uk/research/groups/srcc/projects/video-research.aspx

Where is the VERDIS project up to?

Ethical approval granted

Applying for ethical approval means writing down in a great deal of detail how the project will work. In particular, the ethics committee needs to see all the paperwork, including patient and doctor information sheets and consent forms. They need precise and full details about who will be asked to participate in the research, and what will be said to them. Thanks to our stakeholder consultation, and to support from our project advisors, we were able to provide full details to the ethics committee, and it approved our plans.

Recording equipment bought

We have had fun trying out various camera and voice recording equipment, and have settled on a combination of Canon and GOPRO cameras, with a Rode microphone and Olympus voice recorders.

Video-recording nearly complete

We have recorded 30 consultations. For 26 of these all the patients, carers and doctors recorded have agreed we can use them for the research. When we set up VERDIS, we wanted to make it easy for people to change their mind about being involved after being recorded. Four people have done so - we think this shows our processes are working.

What kinds of consultations have been recorded?

- Inpatients, outpatients, and day therapy patients
- People with cancer, motor neurone disease, and heart failure
- People who are in remission and people who are very unwell (but still able to decide about participating)
- Decision making and planning about lots of different issues – ordering a new mattress, going for tests at another hospital, changing medications, resuscitation decisions, advance care plans about care in the person's last few days or hours

Any results yet?

We really are in the very early days of analysis. However, we know that analysis of the recordings will mean we will be able to provide a lot of new knowledge about communication in palliative care. Or rather, analysis will make explicit a lot of the skills that experienced practitioners use, but which it is hard for them and others to articulate.

As noted, we are examining patient involvement in making plans and decisions. In palliative care, this often requires pretty direct talk about end of life. With colleagues Jane Seymour and Vicky Land, Ruth Parry recently published an article about how to encourage (and discourage) patients in talking about difficult issues such as illness progression and end of life. You can download it here: <http://spcare.bmj.com/content/early/2014/10/24/bmjspcare-2014-000649.full.pdf+html>
See final page of this newsletter for a summary of the article.

They pointed out that we know very little about ways in which patients and staff move from broaching difficult future issues to actually making plans and decisions. We have started to look in our VERDIS data at ways in which doctors can support patients' and their significant others' involvement in planning and decision-making. We are identifying ways in which doctors manage consultations so that each party gets opportunities to express their particular viewpoint. We are also examining interludes of shared humour, and how patient and doctor can come together through these when there is some underlying tension or disagreement. We are also examining how gentle humour can counter the great seriousness and sadness entailed in some of these conversations.

What about the training resources?

We have shown some clips to staff who provide training on communication skills to qualified, non-qualified, and trainee health and social care workers. They have been enthusiastic about the recordings, and anticipate that they will be more powerful than the role-played vignettes they currently use. We are working with a digital learning group at The University of Nottingham to produce a training resource that will be piloted by a number of experienced communication skills trainers in 2015. We will be evaluating trainers' and trainees' reactions to the materials.

Would you like to know more about piloting the training resources?

Please get in touch with Ruth Parry or Idaliza Nukis (details at end of newsletter) for more information.

Other research

In other research...

When doctors and patients do not speak the same language: interpreters improve communication by doing more than just translating

Reference: "Conveying information in the interpreter-mediated medical visit: The case of epistemic brokering" CW Raymond. Patient Education and Counseling 97, pp. 38-46

This video research explored how interpreters help in the transfer of information and advice between healthcare staff and people consulting them.

The author points out that the problem of not 'speaking the same language', is true to some degree in any consultation when staff employ bio-medical terminology and knowledge with which patients are unfamiliar, and that this can lead to various forms of misunderstanding and miscommunication. He points out how the gap can be even greater when doctors and patients

do not share the same culture and language, such as the English-speaking staff and the Spanish-speaking families examined in his research.

Whilst the study aims to identify things healthcare interpreters do in general, the specific setting is paediatrics and genetics. The researchers video-recorded and examined 24 consultations that involved English-speaking geneticists, nurses, dieticians and social workers, Spanish-speaking families, and interpreters who provide English-Spanish translation in the course of the visits.

The study shows that interpreters do well in facilitating staff-parent communication when they do not do things 'by the book', that is, when they do not limit themselves to literally translating what the staff ask or tell the parents, then translating precisely the parents' response.

In one example examined, a dietician gives advice about a particular kind of foodstuff in a way that

takes for granted that parents have enough background knowledge to follow it. Interpreters are able to spot when patients are mystified and they step in to provide additional information to help them make sense of what they are being told or asked to do.

This is visible in the example, in which the interpreter does some background explaining about the food as well as translating dietician's actual words and advice.

The research shows how interpreters can employ not just their linguistic skills, but their interpersonal skills and cultural knowledge in order to support understandings. This allows the communication in the consultation to be optimised and tailored to individual patients. In this way, interpreters can help patients be more active participants in consultations.

For a copy, email marco.pino@nottingham.ac.uk

In other research...

Talking with patients and their significant others about future illness progression and end of life

Reference: "How to communicate with patients about future illness progression and end of life: a systematic review" R Parry, V Land & J Seymour. *BMJ Supportive and Palliative Care* 2014;00:1–11. doi:10.1136/bmjspcare-2014-000649

This systematic review drew together evidence from research studies on audio and video recordings of medical and counselling consultations in which difficult future issues such as illness progression and end of life were discussed. 19 papers were included. Many were published in social scientific journals and books – making it unlikely that clinicians would read them.

The current evidence describes the structure and functioning of several practices:

1. Fishing questions: open questions seeking patients' perspectives – these do not often elicit patients' talk about the difficult issues.
2. Indirect references to the difficult future – these allow clinicians to gently 'push at the door' of the difficult topic. They make it easy for the patient to side-step, but can also be work as a first step towards more direct talk.
3. Explicitly linking to what a patient has already said, or noticeably not said: this frames the difficult topic as relevant to and raised by the patient rather than imposed by the professional.
4. Hypothetical questions: strongly encourage direct talk about difficult future issues. Whilst pushing the difficult topic to the surface, the hypothetical framing helps 'insulate' the patient somewhat from the seriousness of the issue for them personally.
5. Framing difficult matters as universal or general: there is less evidence on these, but they seem to work similarly to hypotheticals.
6. Conveying sensitivity via means other than words, for example, hesitancy, touch.
7. Encouraging further talk from the patient by using means other than words, for example, long silences.
8. Steering talk from difficult/negative to more optimistic aspects. This helps maintain hope, but moving to 'upbeats' early within a conversation on difficult future issues can close off further talk about them.

The communication strategies documented vary in how strongly they encourage patients and their significant others to engage in talk about matters such as illness progression and dying. Fishing questions and indirect talk make it particularly easy to avoid engaging; this may be appropriate in some circumstances – for instance when a practitioner is trying to work out whether it is the right time for the patient to discuss the difficult issues.

Hypothetical questions are more effective in encouraging direct talk about illness progression and dying, as is linking questions to patients' cues. Shifting towards more 'optimistic' aspects helps maintain hope but closes off further talk about difficulties: practitioners may want to delay doing so.

Finally, people use lots of other communication practices when talking about and making plans in relation to illness progression and end of life. These include things like humour, empathy, touch, and negotiation. There has been little research about these. To better support reflective practice and development of skilled communication, we need more evidence about how and when various communication practices get used, and how effective they are in supporting sensitive and effective communication and planning about illness progression and end of life.

Contact details for further information about the project

Dr Ruth Parry, Principal Research Fellow
See details below

or contact

Idaliza Nukis, Research Support and Administrator
LOROS Hospice
Groby Road
Leicester, LE3 9QE
t: +44 (0)116 231 8498
f: +44 (0)116 232 0312
e: idalzanukis@loros.co.uk

For further information please contact:

Dr Ruth Parry, Principal Research Fellow
Sue Ryder Care Centre
School of Health Sciences
The University of Nottingham
Queen's Medical Centre
B Floor, South Block Link Corridor
Nottingham, NG7 2HA

e: ruth.parry@nottingham.ac.uk
w: www.nottingham.ac.uk/research/groups/srcc/projects/video-research.aspx

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