engage local leaders and influencers, provide broader health services, and build in gender considerations to establish trust between members of the public and the public health system.

Theme: What makes good communication: exploring the role of trust and truth in cultivating meaningful health communication

Day 1: Thursday 18th March – 13.35-14.55

21 INTENSIVE CARE PATIENTS' EXPERIENCES AT POST-ICU DISCHARGE FOLLOW-UP CLINIC. ENSURING COMMUNICATION AND EMPATHY AS THE CORNERSTONES TO DEVELOPING TRUST AND PATIENT-HEALTHCARE WORKER RELATIONSHIPS

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10.1136/bmjopen-2021-QHRN.59

Introduction Post Intensive Care Syndrome (PICS) describes the health problems that remain after critical illness. PICS has become an increasingly recognised problem in survivors of severe critical illness. These problems fall into three broad categories: physical, cognitive, and psychiatric impairment.

Methods After commencing a post-ICU discharge clinic to enable follow up of ICU patients post-discharge, we conducted a Phenomenological study exploring and illuminating the experiences of the first patients referred to the clinic. The data was analysed using Interpretative Phenomenological Analysis, identifying two superordinate themes.

Results The superordinate-theme 'I have a voice: you're just not listening' had three themes; Patience, not predictive text-describing patient's frustrations at people's inability to wait for their prolonged communication to finish; 'Yes, I did just say that'- describing patient's frustrations that people were not accepting they were having have bad days too; 'Talk to the hand'- describing patient's frustration at people not picking up on body language when they couldn't use their mouth.

The superordinate-theme 'Wear my shoes: empathic understanding' had three themes; 'Care not pity'- describing patient's need to have their carers help them to get better rather than feel sorry for them; 'From the minute I wake up'- describing patient's need to have people show empathy at all times, as a single lack of it is devastating; 'Small things are massive'- describing patient's need for people to see what might seem a small issue can be overpowering at that moment.

Conclusions Whilst empathy and communication are often discussed as vital aspects of patient care, this study provides context and examples of how they impact everyday practice for all healthcare staff, allowing the formation of trust and a conducive patient-healthcare worker relationship. This contextualised and humanised approach to patients will guide ICU staff in how to improve the management of future ICU patients.

22 TRUTH AND TRUST IN TREATMENT ADHERENCE: A QUALITATIVE STUDY OF THE IMPACT OF ELECTRONIC MONITORING OF ADHERENCE TO NEBULISER TREATMENT ON THE PATIENT-HEALTHCARE PROFESSIONAL RELATIONSHIP

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10.1136/bmjopen-2021-QHRN.60

Background Healthcare professionals often expect that people with cystic fibrosis should be adhering to complex daily treatments regimens. Until the recent onset of technology such as electronic monitoring of nebuliser treatments, clinical teams had to trust that their patients were truthful in their subjective adherence reports. However, trust in this relationship goes both ways; patients also had to trust that their clinical team believed them.

Aim To explore acceptability of an intervention to increase adherence to nebuliser treatment in adults with cystic fibrosis.

Methods We interviewed 22 patients and 26 interventionists about their views of the intervention. We used deductive and inductive framework analysis to analyse the results.

Results We found that issues of trust and truth regarding subjective treatment adherence had a great impact on the relationships between clinical teams and patients. For some patients the introduction of objective data provided proof of adherence that gave them confidence that their clinical team now had to believe them; however, for others it meant that they could no longer hide the truth about low adherence and had to face up to how this affected their relationship with the clinical team. Healthcare professionals talked about how prior to having objective data, despite wanting to believe patients, judgements had often been made about whether to believe patients' subjective adherence, without evidence. Proof of adherence, or non-adherence was a starting point to facilitate honest discussions that may have been harder to initiate otherwise. However, the key to using adherence data was for clinical teams to build a trusting clinical-patient relationship by maintaining a non-judgemental approach which encouraged patients to be truthful.

Conclusions Issues of trust and truth are important in building relationships between people with cystic fibrosis and the clinical teams involved in their care in this new electronic monitoring intervention.

23 HOW PHYSICIANS' TRUST IN THEIR PATIENTS IMPACTS THEIR COMMUNICATION AND DECISION-MAKING PROCESSES

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10.1136/bmjopen-2021-QHRN.61

Background Patients' trust in physicians has been identified as essential to establishing relationship, receiving reliable information and treatment adherence. Less is known about physicians' trust in their patients. Physicians' trust may play an important role especially during complex, long-term relationships with patients dealing with a chronic illness such as Diabetes.

Aim To learn about physicians' perceptions of trust in their patients and understand how these perceptions impact their patient-physician communication.

Methods A qualitative study using an Immersion/Crystallization thematic analysis of 23 semi-structured interviews with physicians, specializing in Diabetes. Analysis included both horizontal (focusing on each interview separately) and vertical (comparing different interviews) analysis to learn how different physicians perceive their relationship with Diabetes patients and the communication skills they use.

Results Physicians discussed the complexity in Diabetes care, including the need to rely on their patients to manage their disease and adhere to the challenging treatment plan. They mentioned their feeling of limited control over this adherence.

Some have come to terms with this limited 'control' and accepted their reliance on the patient. These physicians invested in building a relationship and mutual trust with the patient, accepting his involvement as a key partner in treatment decision-making.

Others, found relying on the patient challenging. They were concerned with their responsibility and felt frustrated and intimidated by the limited control. They invested in preserving and enhancing control over the decision-making, including using tactics and persuasion or intimidation, to increase adherence.

Conclusions Physicians' trust in their patients, and their perceptions and acceptance of the limited control, play a significant role in the way they communicate and share decisions. Providing them tools to reflect and deal with their perceptions, accepting the limited control, and enhancing their trust in their patients, can help them cope with these challenges and communicate in a more patient-centered manner.

Day 2: Friday 19th March – 14.50-15.50

24 THE IMPLICATIONS OF UNDERMINING AND BREACHING TRUST IN MATERNITY CARE; FINDINGS FROM THE WRISK PROJECT

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10.1136/bmjopen-2021-QHRN.62

Background Women receive many public health messages relating to pregnancy which are intended to improve outcomes for babies and mothers. However, negotiating risk and the maternity system can feel confusing and dis-empowering. Relationships between women and their carers are central to maternity care trajectories but can be adversely affected by issues of trust and autonomy.

Aim/Objectives To explore issues in the communication of pregnancy-related risk; to articulate women's experiences and develop co-produced recommendations to improve pregnancy-related risk communication.

Methods We used an online survey and qualitative interviews to gain an understanding of women's experiences of advice, support, and decision making in pregnancy. The survey was disseminated through a Facebook advertisement inviting women 16–45 years across the UK to participate. Data was collected between June–August 2019. Survey participants were sampled to ensure the interview population included women whose voices are seldom heard and disproportionately impacted by poor risk communication. Data was collected between April–November 2019.

Results Over 7,000 women completed the survey and 34 women then participated in interviews. 29% of the interview population were BAME and 29% received means-tested benefits. Many women initially implicitly trusted their healthcare providers (HCPs). However, partial advice from HCPs, particularly around medication, was a source of anxiety for women. Participants reported that the use of screening to 'catch them out' about smoking undermined their relationships with midwives. Several women living with obesity reported their data being shared with third parties, further undermining trust. Some reported lying to their midwives about their behaviours because they felt judged.

Conclusions Our findings show the importance of risk communication that respects women's autonomy and trusts them to make decisions about their own pregnancy. When trust breaks down some women may be more likely to hide their behaviour. Our research highlights a need to improve risk communication within maternity care.

25 SHARED DECISION MAKING FOR HIGH RISK MAJOR SURGERY: GENRES OF CONSULTATION

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10.1136/bmjopen-2021-QHRN.63

Shared decision making represents a shift from a paternalistic, 'doctor knows best' approach to a collaborative approach that values and centres patients' knowledge of their own best interests. Resources such as training for clinicians, awareness raising for patients and the public, and decision support tools are used to achieve shared decision making. Despite these efforts, patients can feel that they have little choice about treatment, and some patients say they prefer to trust in their clinicians' recommendations. During our qualitative study of how patients, their families and clinicians make decisions about high-risk major surgery (Shaw et al., 2020), we asked: to what extent can shared decision making address the asymmetries of power and knowledge between patients and clinicians as they approach decisions about treatment?

Informed by ethnography of communication, we drew on the concept of genre in our analysis of empirical data (video recordings of decision-making consultations, interviews with patients, family members and clinicians and ethnographic field-notes). We analysed the interactions between context and language, considering how talk during consultations between surgeons, patients and family members interacted with the clinical, organisational and social context of the decision. We found that shared decision-making was understood and practised in distinct, varied ways to produce three different genres of 'decision-making' consultation: 'problem-solution', 'option selection' and 'assessment of benefit'. These genres served different functions, shaping the extent to which patients perceived and participated in decision-making.

We consider the implications of how different external framings (how and when the consultation was organised in relation to the patient's trajectory) and thematic framings (how clinicians and patients approached the consultations) shaped the resulting genre of consultation. We conclude that attempts to address asymmetries of power and knowledge through decision-making talk during consultations can potentially be thwarted by the framing effects of the clinical, organisational and social context.