Results Four models to engage children as patient-partners have been identified: (1) Moving from family-centred care to child-centred care; (2) Using a triadic approach involving the healthcare professional, parent and child; (3) Using family-centred care while acknowledging the vulnerability of the child; (4) Involving the child patient on a level of participation based on cognitive development and competency. Throughout the analysis process, we identified ethical challenges that can occur when using the different models. Establishing trust with children and addressing issues related to power are the two most prevalent ethical challenges reported.

Conclusions The presentation will focus on these two key ethical challenges and highlight the different perspectives (i.e. from children, parents and healthcare providers) present in the qualitative literature on how to build trust with children in health services planning and delivery.

7 WOMEN'S ACCOUNTS OF ALTERED FETAL MOVEMENT: UNRELIABLE AND PRIVILEGED

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10.1136/bmjopen-2021-QHRN.7

Background Sociological literature has reported widely on the subjugation of pregnant women's embodied knowledge to obstetric technologies. Women's accounts of altered fetal movement have sometimes been dismissed, with poorly-managed episodes of reduced fetal movement highlighted as an important contributory factor to avoidable stillbirth. NHS England's 2016 Saving Babies' Lives care bundle included recommendations for the management of reduced fetal movement as part of a national strategy to reduce stillbirth.

Aim To explore how different forms of knowledge about fetal movement are evaluated and prioritised before, during and after the clinical encounter.

Methods This research used an ethnographic approach to compare practice relating to fetal movement at two UK maternity units, with over 200 hours of observation, interviews, and document analysis. Field notes, interview transcripts, policy documents, maternity notes and clinical guidelines were analysed to identify key themes.

Results Despite no cases of women's accounts being dismissed, many clinicians presented altered fetal movement as a highly subjective and unreliable symptom. Women's reports of a quiet baby were not always consistent with clinicians' own impressions of fetal movement, or with the evidence generated by 'objective' monitoring devices. Nonetheless, in accordance with clinical guidance, if a woman reported altered fetal movement at or beyond 39 weeks' gestation, the decision to expedite the birth through induction of labour was regularly made based on her account alone.

Conclusions In the risk-averse maternity setting, and amid a national campaign to reduce stillbirth, clinicians are under considerable pressure to act promptly on women's reports of altered fetal movement, whether or not they trust them. This imperative to act without clear evidence of fetal compromise can be interpreted as a disruption to the established knowledge system, with women's embodied knowledge apparently being privileged – in this scenario at least – over the evidence generated by high-status obstetric technologies.

8 'DEALING WITH THE BABY YOU LOST AND THE LOSS OF THE FUTURE': CHI – A RECURRENT PLACENTAL CONDITION

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10.1136/bmjopen-2021-QHRN.8

Background Chronic histiocytic intervillitis (CHI) is a rare, poorly-understood placental condition causing pregnancy loss. Unlike many other causes of stillbirth, CHI has a recurrence rate of 50–80% in future pregnancies and has limited treatment options.

Objectives To understand the impact of CHI on women who have experienced pregnancy loss and to ascertain their healthcare needs.

Methods We conducted a focus group discussion (FGD) with three women affected by CHI, recruited through a Facebook support group. The FGD was facilitated by the lead author and a peer-researcher. It was transcribed verbatim and analysed thematically. It is part of a larger clinical study (MIR-APO) which was approved by the London Research Ethics Committee (19/LO/0105).

Results Lack of knowledge about CHI amongst healthcare providers (HCP) often resulted in inadequate or inaccurate explanation of the condition; limited advice on future treatment options; and lack of patient information. This led women to lose trust in HCPs, feeling that they had to seek and arrange their own care, often drawing upon a network of other women with CHI.

The recurrent nature of CHI is particularly challenging, causing women to lose trust in their ability to carry a baby. They described a 'double grief': firstly, for their loss of their baby; secondly, for the loss of the future they had envisaged. The high likelihood of recurrence provoked anxieties about future pregnancies, including unproven treatment regimens and the possibility of further loss. Participants identified continuity of care from HCPs (e.g. bereavement midwives, or an obstetrician familiar with CHI) as an important source of hope and support.

Conclusions Lack of awareness around CHI leads to inaccurate information, misplaced reassurance, and failure to refer for appropriate management. This erodes trust and has significant psychological sequelae. In response to these findings, we are developing resources on CHI for patients and providers.

9 COMMUNICATION OF UNCERTAINTY, DIAGNOSIS AND TRUST

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10.1136/bmjopen-2021-QHRN.9

Background Diagnosis is a complex and challenging clinical and communicative task. The rate of diagnostic errors, including missed, delayed, and misdiagnosis, has remained prevalent at 10–15% over the last few decades (Graber, 2013). Diagnostic errors can be a major cause of loss of trust in the doctor-patient relationship. Clinicians use 'diagnostic statements' to name, describe or explain the health problem to patients. If uncertain, clinicians are encouraged to share their working diagnosis and give an indication to their level of uncertainty.

Communicating uncertainty can impact the success of relational trust in medical interactions. But, research on the communication of diagnostic uncertainty is sparse.

Objective To explore links between communication of uncertainty in diagnostic statements and trust in doctor-patient interactions.

Methods Combining interdisciplinary insights from medicine and applied linguistics, we analysed a corpus of 16 transcribed, video-recorded role-plays recorded during a practice high-stakes exam for international medical graduates (n=16) to gain medical accreditation in Australia. Fifty percent of doctors communicated the correct diagnosis. Analysis of the entire interaction traced discourse features associated with building relational trust. Informed by literature, we identified all diagnostic statements and analysed deductively for type of statement, ranging from plain assertions, to providing evidence to generalisations, and to identify implicit and explicit discourse feature associated with expressing uncertainty.

Results Preliminary results showed that in role-play interactions with incorrect diagnosis clinicians drew more heavily on evidence in their diagnostic statements than in interactions with correct diagnoses. This suggests that clinicians might seek to build trust by supporting uncertain diagnosis with evidence.

Conclusion There is a complex interplay between a clinician's accuracy of diagnosis, their use of implicit vs. explicit expressions of uncertainty (e.g. modal verbs vs. 'I don't know') and the creation of trust. We are currently exploring this complex relationship to understand how trust can be enhanced.

10 'IT'S ABOUT PUTTING ON DISPLAY A SHOW, BUT ACTUALLY ALL THE DECISIONS ARE BEING MADE BACKSTAGE': PUBLIC INVOLVEMENT IN DECISIONS TO CHANGE HEALTH SERVICES AT A LARGE-SCALE

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10.1136/bmjopen-2021-QHRN.10

As proposals for large-scale change (LSC) to health services are associated by the public with making cuts and downgrading services, public involvement – a dominant motif in national healthcare policy – is thought as a way to legitimise plans and resolve tensions. Yet, little is known about how involvement is interpreted and operationalised or how it may impact LSC plans and resolve controversy.

This grounded theory study explored the social and political dynamics underpinning public involvement in two English communities facing service closures under a regional LSC programme. Document analysis, 27 interviews (with the public, campaigners, politicians, clinicians, Healthwatch, involvement practitioners and decision-makers) and over 100 observations hours were conducted to build a comprehensive model for involvement in LSC.

The resultant theory is set against the backdrop of a changing health system. Invited involvement, stemming from technocratic processes institutionalised within health services, was experienced by the public as inadequate, manipulative and having no influence on decision-making. By instrumentalising

involvement to manage opposition and constrain public deliberation, health planners created an environment of distrust, omnipresent during fieldwork. Rather than address issues of trust, health planners became 'entrenched', further fuelling opposition and self-mobilisation of the public. Hence, the public actively questioned the evidence for change, opposed LSC plans and sought alternative uninvited routes to voice their views and challenge change. While the technocratic model aimed to depoliticise LSC, uninvited actions – initiated by members of the public turned campaigners – were a means to re-politicise it. Campaigners added another layer of scrutiny on decision-makers and contributed to the delay of service closures.

Distrust in involvement is long-lasting and shapes future relationships with the public, even after controversial plans are dropped. This grounded theory study provides a more nuanced understanding of public involvement in controversial LSC and seeks to contribute to current debates.

11 BACK TO MEDICAL AUTHORITY: HOW TRUST DEFINES THE WAY OLDER PEOPLE IN SAO PAULO SEARCH FOR HEALTH INFORMATION AND CARE

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10.1136/bmjopen-2021-QHRN.11

At the same time Dr Google, specialized Youtube channels and m-Health apps provide an unprecedented amount of health information, the deliberation about what content to trust challenges people's empowerment and autonomy to manage their own health. Based on a 16-months ethnography conducted in São Paulo, Brazil, we address the role trust plays in the strategies adopted by older people to consume health information and to achieve medical guidance through WhatsApp. In this work-oriented community, curating useful information is one of the activities older people do after retirement. By sharing them on their multiple WhatsApp groups, they can recover their sense of utility. Health tips and information are among the contents they share the most. As the reputation as curators is attributed to the person who shared the information first, they are in a running for novelty. As a consequence, it is common that they end up sharing fake news. They usually explain they didn't check it because they trusted the person who shared it first. One-quarter of Brazilians evaluates the veracity of content based on the same criteria. Moreover, health content usually refers to a doctor or institution, which can also gain older people's trust as they still respect medical authority. Medical authority is also what they seek for when they need assistance. However, they bypass the health system bureaucracies and ask their friends for guidance on WhatsApp. These friends (or friends of friends) are not any friend, but those who work in healthcare are. With this specificity, they can achieve guidance that is at the same time informal and professional, as these friends are medical authorities they feel they can trust. Despite all information available online, this work aims to discuss how trust, intrinsic to human relations, can be determinant to our relationship with technology, health and care.