#7408 Bedre medvirkning ved MS-behandlingsvalg

SØKNADSINFORMASJON

Søknadsid	7408
Utlysning	Forskning (2015)

PROSJEKTETS VARIGHET

Prosjektets varighet (antall år)	3
Forventet startdato (dd.mm.åååå)	01.01.2015
Forventet sluttdato (dd.mm.åååå)	31.12.2017

OPPLYSNINGER OM STIPENDIAT

Prosjektleder/forsker kontaktinformasjon

OPPLYSNINGER OM HOVEDVEILEDER

Fornavn	Pål
Etternavn	Gulbrandsen
Akademisk grad	Professor dr.med.
Annen akademisk grad	
Fødselsår	1955
Kjønn	Mann
Telefon	67968718
Mobil	95827288
E-post	pal.gulbrandsen@medisin.uio.no
Post ønskes sendt til	Arbeidsstedsadresse
Privatadresse	
Postnummer	
Poststed	
Land	
Arbeidssted	Universitetet i Oslo
Postadresse	Forskningssenteret, Akershus universitetssykehus, Postboks 1000
Postnummer	1478
Poststed	Lørenskog
Land	

OPPLYSNINGER OM EKSTERN INSTANS OG ARBEIDSGIVER

Ekstern instans for prosjekt Akershus univ.sykeh.

Ekstern instans - fritekst

SAMARBEIDSPROSJEKT

Er dette et samarbeidsprosjekt mellom flere frivillige organisasjoner Nei

Samarbeidende organisasjoner

Navn på organisasjon	Kontaktperson	E-post

PROSJEKTINFORMASJON

Hvilket helseområde faller prosjektet inn under Somatisk helse

Alderskategorier
Voksne (20-66 år)

Geografisk område

Er prosjektet landsdekkende? Nei

Hovedfylke for prosjekt Akershus

Andre fylker for prosjekt? Ja

Andre fylker for prosjekt
Oslo

BUDSJETT

Budget reference

Inntekter	2015	2016	2017	Periodetotal
ExtraStiftelsen	100%	100%	100%	2055449
Egne midler	0	0	0	0
Offentlige midler	167000	167000	167000	501000
Andre inntekter	0	0	0	0
Delsum	832000	851950	872499	2556449

Utgifter	2015	2016	2017	Periodetotal
Lønn, sosiale utgifter	769000	769000	769000	2307000
Innkjøpte tjenester/honorarer	43000	62950	83499	189449
Materiell/utstyr	0	0	0	0
Andre utgifter	20000	20000	20000	60000
Delsum	832000	851950	872499	2556449

Total	0	0	0	0

FORSKNINGSMETODE

Forskningsmetode Kvalitativ/Kvantitativ

PROSJEKTTEMA

Prosjekttema (på norsk) Hvordan pasienter informeres om og involveres i beslutninger om behandling ved multippel sklerose, forbedring av dette

SAMMENDRAG

Bakgrunn for prosjektet og hva er kunnskapsstatus i dag Pasientmedvirkning ved beslutninger om behandling er lovfestet, men leger er ikke skolert i dette. I dag blir pasienter involvert uten å bli forklart hvorfor, og de får mangelfull, skjev eller irrelevant informasjon. Vi vet for lite om hvordan legen i detalj kan forbedre denne situasjonen.

Prosjektets målsetting Overordnet mål er å bidra til mer kunnskap om hvordan leger på en god måte kan gi kompleks informasjon om behandlingsalternativer. Moderne behandling for multippel sklerose (MS) krever vanskelige avveininger, og egner seg derfor godt for å studere dette. Vi vil sikre bedre prioritering og formidling av skreddersydd informasjon til MS-pasienter, og teste ut en metode som vi venter vil ha stor effekt. Brukere involveres i hele prosessen.

Design, metode og materiale

Det vil være to delstudier, en deskriptiv og en eksperimentell. Til sistnevnte vil vi ved hjelp av brukermedvirkning og data fra den deskriptive studien utvikle et kjerneinformasjonsark. Den deskriptive studien vil bygges på innsamling av videomateriale fra lege-pasientsamtaler der pasienten informeres om behandlingsalternativene ved multippel sklerose som krever langtidsbehandling. Videoene vil bli beskrevet med kjente kodesystemer for pasientsentrert kommunikasjon. I den eksperimentelle studien vil leger i et randomisert design informere pasienter først på vanlig måte, deretter på (presumptivt) bedre måte etter opplæring. Effekten evalueres med intervjuer og spørreskjema til pasientene. Pasientene i eksperimentet har MS, men står ikke i en reell valgsituasjon. Vi ønsker å påvise en stor effekt i et laboratorium før vi prøver dette ut i virkeligheten, analogt til en medikamentstudie.

Vitenskapelig betydning, hvilken ny kunnskap kan dette prosjektet bidra med Hvis informasjonsmetoden har den effekten vi håper å påvise, vil det få stor betydning for hvordan nevrologer diskuterer behandlingsalternativer med MS-pasienter i fremtiden. Siden informasjonsmetoden er enkel og generell, antar vi at kunnskapen vil ha stor overføringsverdi til pasientmedvirkning generelt i medisinen. Studien vil også belyse en detalj i pasientsentrert kommunikasjon som ikke tidligere har vært beskrevet tilfredsstillende.

Samarbeidspartner(e)

Jürgen Kasper, Universitetet i Tromsø.
Edward Krupat, Harvard, USA.
Kjell-Morten Myhr, Helse Bergen og Universitetet i Bergen.
Reidun Førde, Universitetet i Oslo.

Fremdrifts- og tidsplan med planlagte publikasjoner

2014 - Godkjenning i etisk komite.
2015 - Innsamling av data til deskriptiv studie og forberedelser til eksperimentell studie. Til disse forberedelsene hører utarbeidelse av spørreskjemaer, intervjuguider og måleinstrumenter. Vi understreker betydningen av konkrete mål med forventet stor effekt, som er begrunnelsen for en studie med få deltakere i hver arm.
2016 - En publikasjon fra deskriptiv studie, innsamling av data til eksperimentell studie.
2017 - To publikasjoner fra eksperimentell studie og avhandling.
Datainnsamlingen vil gi rom for en rekke sekundæranalyser.

VEDLEGG

Prosjektbeskrivelse	1 vedlegg
	Enabling shared decision making MS treatment May 16 2014.pdf
CV for doktorgradsstipendiat	1 vedlegg
	PhD candidate CV.pdf
Publikasjonsliste for doktorgradsstipendiat	0 vedlegg
CV for hovedveileder	1 vedlegg
	CV English May 2014.pdf
Publikasjonsliste for hovedveileder	1 vedlegg
	Publication list Gulbrandsen May 2014.pdf
Anbefaling fra veileder	1 vedlegg
	Anbefaling 15 mai 2014.pdf
Godkjenning av prosjektet fra ansvarlig leder	1 vedlegg
	Institusjonsanbefaling 15 mai 2014.pdf
Egenerklæring fra samarbeidspartner(e)	3 vedlegg
	Collab intent Forde 2014.pdf
	Kasper_declaration.pdf
	Let of collab Krupat.pdf
Detaljert budsjett ved behov	0 vedlegg
Andre vedlegg	1 vedlegg
	Egenerklæring fra den fjerde samarbeidspartneren KM Myhr

Enabling shared decision making about treatment with multiple sclerosis patients: A preclinical intervention study

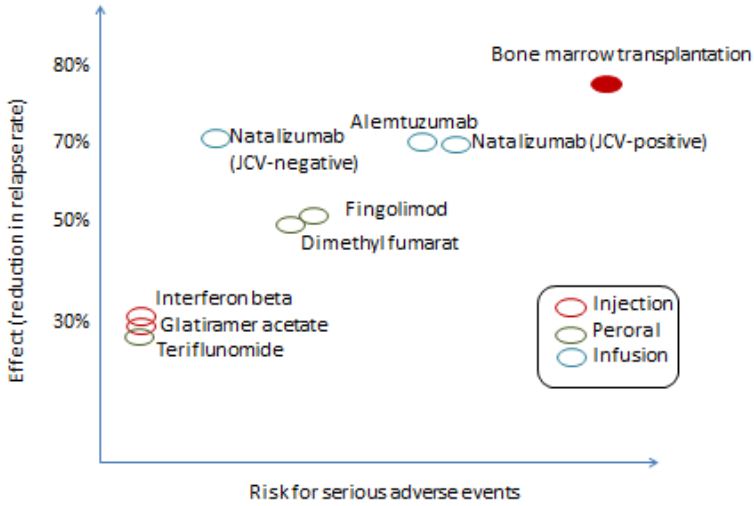
Background

It is an ethical imperative of modern Western medicine for doctors to discuss treatment with their patients, and it is mandated in Norwegian law [1,2]. This activity is one of several elements included in the concept patient-centered care [3,4]. Two concepts are used, *shared decision making* (SDM) [5-9] and *informed decision making* (IDM) [10]. SDM is more widespread than IDM, and we will use that term in the following. SDM aims to support patients in deliberation and determination around decisions where there is equipoise.

Doctors strive to balance between paternalistic decision-making, appropriate information giving, more or less concealed persuasion or sometimes even complete handover of the decision to the patient [11]. Patients often get confused, particularly when they are given choices without sufficient information about the alternatives or about why the doctor asks them to decide. However, informed and active patients tend to adhere better to the chosen treatment and to be more satisfied with their healthcare [12]. The ability of doctors to practice the involvement of patients in decision making appropriately is still not widespread [13] and has led some critics to abandon the idea [14]. One reason could be that training programs in patient-centered care comprise too many general skills, and results are mixed [15]. This study aims to test simple SDM training initiatives focusing on information giving. New treatment options for multiple sclerosis patients introduce a complex information situation, well suited for development and testing of new, concrete improvements in SDM.

Multiple sclerosis (MS) is the most common disease cause of neurological disability among young adults in Western societies, affecting approximately 10,000 Norwegians [16]. The incidence is increasing, particularly among women [17].The disease is characterized by an unpredictable course, and has a severe impact on health-related quality of life [18]. Untreated, the majority of patients will over the years develop secondary progressive disease with increasing and permanent disability.

Current immune modulatory treatment in MS may stop disease progression – no drug reverses established disability [19]. Treatment must therefore start early, before permanent disability develops [20]. Available drugs differ in efficacy, risk/adverse effect profile and administration form. Direct comparisons of effects are complicated as head-to-head studies are generally lacking. Figure 1 illustrates reduced relapse rate versus drug associated risk for serious adverse events.



MS patients will need to be informed about different effect sizes, infrequent and very different serious adverse effects (heart block, hematophagocytic syndrome, encephalitis, progressive multifocal encephalopathy, impairment of vision (macular oedema), possible increased cancer risk) related to the drug alternatives, and all in light of limited experience due to short observation time for the new drugs (compared to the duration of MS) [21-25]. The complexity of the information is reflected in frequent updates of the Norwegian Health Directory guidelines for MS treatment. According to the Norwegian Health Directory guidelines for MS treatment most patients should initially be treated with glatiramer acetate, interferon beta 1a/b, teriflunomide or dimethyl fumarate[21]. Fingolimod, natalizumab and alemtuzumab should be used as escalation therapy if first line drugs fail, and from the beginning in a minority of patients with severe disease. There is, however, room for interpretation in individual cases, reflected in extensive difference in the use of disease modifying MS drugs between counties in Norway. According to the prescription registry, both the total use and the ratio between the different drug classes differ by more than 50%. These differences cannot be explained by differences in prevalence or incidence, which is quite uniform across Norway [26]. They are therefore likely to reflect differences in doctor (and, less likely, patient) preferences and in tradition related to decision making, and should give rise to ethical concern.

Decision making. The decision on initiating MS treatment is a process involving both the neurologist and the patient, and in many cases also other actors like MS nurses, relatives and friends. There are several factors that make this choice difficult for patients: First, it requires knowledge about the individual prognosis as well as the pros and cons of the treatment options. Second, the decision often has to be made in a period of emotional chaos and distress. In order to involve the patient, the doctor must provide sufficient information. On the other hand, too detailed or otherwise poorly communicated information may enhance uncertainty and despair, and thereby reduce the patient's capacity or wish to be involved in the decision making. The complexity of this decision is reflected by research in Italy and Germany [27,28], with an emphasis on patient information. The task calls for doctors who are well skilled in patient-centered care and SDM.

SDM in medicine is a rapidly growing research field. Most studies on medical decisions and patient-doctor communication have been performed to assess the degree of patient involvement. SDM studies are predominantly descriptive, combining observation of real

doctor-patient encounters with patient reported outcomes (mainly various satisfaction scores) after such encounters. Experimental studies are few. Interventions are either more general training in patient-centered care and/or SDM (also done by our group with success [29]), or various preparations of patients (decision aids, pre-encounter information etc) [30]. Training often aims to alter physicians' behaviour by introducing a set of skills, and it is usually difficult to determine exactly which element that explains observed effects on patients. We have not found intervention studies based on the changing of one particular skill. Measurements are also a challenge, and low correlation between instruments of conceptual similarity has been observed [31]. A new promising instrument (MAPPIN'SDM) which encompasses observations of the decision making process from three angles, the doctor, the patient, and the observer, has been developed recently by a research group we have initiated collaboration with [32].

In the case of deciding whether to start second line treatment in MS, the main challenge is to convey sufficient information in a way the patient can handle in that emotional situation. Unpublished qualitative observations in our own large dataset [29] suggest that this requires that the doctor prioritizes, rations, and portions the information.

- Prioritize: Decide up-front which information that the patient must have in order to be sufficiently informed

- Portion: Allow a micropause (1-2 seconds) after each sentence to check visually if the patient follows, also providing an opportunity for immediate questions

- Ration: During the consultation, assess – given the patient's emotional state, questions and the time available – how much additional information to provide there and then, and what and when to provide more

Of note, this approach is not contradictory to patient-centered communication and shared decision-making. The point is that the doctor has to be more thoughtful about his information giving up-front, and equally aware of the patient's reactions under way. He is also instructed to use clearer sentences and fewer words. By doing so, there is less room for assumptions about the patient and more room for the patient to question.

We propose that a simple intervention where the doctor changes just this part of the communication could render high effect on patient take-up, understanding, and ability to decide what to do. If we can provide evidence that very simple and highly specific changes in communication helps patients and doctors in this challenging situation, it will potentially improve the care of MS patients, and may also provide a model for clinicians in other fields in corresponding situations.

A new type of translational research. It is rare to see health services intervention studies with trials in different phases, analog to drug effect studies. In communication research it has hardly ever been done. We think it is necessary to conduct proof-of-principle studies in laboratories before implementation in large scale trials. In real – and difficult – clinical situations, it is unlikely that patients, or doctors, will accept to participate in behaviour intervention studies unless prior studies under controlled conditions have shown promising effects. Hence, this proposal is about trying out a behaviour intervention in a lab in order to explore whether this intervention is worthwhile studying in a clinical trial.

Aim of the project

The overall aim of this project is to improve patients' involvement in decision making by introducing small, highly specific behaviour changes of doctors, using the initiation of MS treatment as an example.

Specific subgoals are:

1) To develop a consensus based fact sheet through involvement of an ethicist, neurologists and patient representatives, that designates which information should be given priority in consultations about treatment choices, built on updated knowledge from clinical trials and clinical registries on treatment effects and side effects, and guidelines of evidence based patient information

2) To observe how doctors communicate treatment options to MS patients, in order to

    a. Describe today's typical behaviour related to MS treatment decisions, and use this as a validity check for the non-intervention arm in the behavioural experiment

3) To test the effect of a simple, highly specific communication intervention, established through instructions to doctors, on patients' information uptake, understanding, willingness and ability to make a decision in a communication lab, including

    a. The main effect study

    b. A study that evaluates the ability of the doctors to adhere to the taught intervention

Methods

Subgoal 2 is covered by study 1, subgoals 1 and 3 by study 2.

Study 1 – Observation of current practice and preparation for experimental study

We will videotape at least six encounters with different doctors and patients. Videotapes will be used to describe which information patients are given, and how, using qualitative analysis according to Miller & Crabtree [33], and based on observation of specific elements in the Four Habits Coding Scheme (4HCS) [34]. The 4HCS is suitable for measurement of patient-centered behaviour. This real encounter measurement will be compared with the non-intervention arm encounter measurements in study 2 to see if the experimental situation diverges much from a normal situation regarding patient-centered behaviour.

Right after the encounter, the patients will be interviewed by a researcher, who uses a structured interview to map the patient's information uptake, understanding and thoughts about the decision. Doctors will also be interviewed about their experiences in the consultations. The study will be used to inform the creation of the fact sheet (see study 2).

We will include doctors for study 2 among doctors in study 1. Criteria are that we do see a potential for improvement on information giving (habit 4 in 4HCS), and that they have an acceptable standard regarding ability to manage emotional issues (habit 3 in 4HCS). The latter is necessary because in this particular study we do not want to manipulate the affective part of the doctors' communication style, and need to have reasonably well-functioning doctors in that respect. In an exploratory study this is necessary, while in a large scale trial it is not. Any exclusion will be on very strict criteria, e.g. extremely poor empathic performance or extremely well-functioning information giving (which leaves little or no room for

improvement). Our assumption is that all six doctors will satisfy inclusion criteria for study 2. We might need to add encounters until we have a sufficient number of doctors.

Publications from study 1: 1-2 qualitative articles that include quantitative assessments in a communication journal (Patient Education and Counseling) or MS journal.

Study 2 – The experimental study

A panel of an ethicist, experienced neurologists with MS expertise and MS patient representatives (volunteers from the Norwegian MS Society have confirmed willingness) will prepare a fact sheet describing in detail a) the crucial information that has to be given to the patient, and b) optional information that may be given as a result of the natural development of an encounter in which treatment options are presented. Available guidelines will be used, and experience gathered from interviewing patients in study 1 will be taken into account.

Intervention: Participating doctors will meet patients in a communication lab. The doctors will first perform encounters with their current information giving style. Then they will be exposed to a short training session focusing on improved information giving, using prioritization, portioning, and rationing. Afterwards, they will perform encounters using this method.

Participating patients: We will include relapsing remitting MS patients that currently use any of the first line drugs, and who have not previously been exposed to the decision to begin with a second-line drug. Patients will be identified in the electronic patient records at Akershus University Hospital (AHUS), and invited to participate through mail. They will serve as proxies for patients in a real choice situation.

Reasons for choosing such patients are that

- It is very hard for a healthy person to imagine how it is to be an MS patient
- MS patients treated with first line drugs represent a subgroup of patients that could be eligible for second line treatment, and are therefore as close to the target population as possible.
- Real patients would be too few within the time frame of this part of the study, which has to be performed in a single center because of the need for a lab facility.

The use of MS patients that are not in a real choice situation could lead to less information uptake ("this is not *that* important for me") or higher information uptake (being less emotionally involved). So to use such patients is a trade-off, in which we balance feasibility (experimental control, small scale trial, costs) with validity. In our opinion, a large scale multicentre trial where doctors in several sites need training and real patients are involved, is prohibitive unless we have clear indications that the behavioural change we want to induce is possible and proves to improve patients' information take-up and ability to participate in the treatment decision.

Sample size estimation: We want to document a strong effect, as we think this is necessary to convince future doctors to accept and adapt such a behavioural change. We expect a strong effect from the present intervention, since it is simple to learn and tailored to the selected patient population. The scale of measurement will be developed for the present project, so the numerical effect size, as well as its natural variability, is unknown (see outcome variables). Our best guess is that the average effect of the intervention will be similar to the standard

deviation of the measured effect. Under standard assumptions of a two-sided t-tests of statistical significance at the 5% and 80% power, this gives 16 patients in each arm of the study.

Preparation of doctor: The study doctor needs to remember the fact sheet information. The doctor is instructed that the encounter follows recent information about the disease activity of this patient, that warrants a discussion about whether to start with second line drugs or not.

Preparation of proxy patient: The patient is told that the study is about how the doctor communicates (but not anything specifically about the concrete intervention and aim). They are instructed to imagine that the current meeting is a real one, although the doctor will present them to information that is not real. Written informed consent is to be acquired at this point.

Randomization: Participating proxy patients are randomized to receive normal or intervention doctor behaviour, and scheduled to meet in the lab accordingly.

Encounter: The doctor has 20 minutes to his disposal to inform the patient. The encounter is filmed, while the researcher simultaneously observes which information that is given. The doctor will not be interrupted if he exceeds the time limit, and encounter duration will be measured (confounding variable).

Post-encounter interview: The researcher performs a structured interview with the patient, with primary purpose to describe as precisely as possible what the patient remembers of the information he/she received, how the information is understood, whether he/she feels equipped to make a decision, and how the patient feels about this decision. The interview is filmed (for documentation/validation purposes), but concrete data are entered in a prepared data sheet by the researcher during the interview. In addition, the patient will complete a recently developed risk knowledge questionnaire (RIKNOW) (http://www.automsproject.org/) which we are allowed to use by our collaborator Jürgen Kasper.

Post-encounter questionnaires: The patient and the doctor complete post-encounter electronic questionnaires about emotions during the interview [35-37]. These data will be used as independent variables in predictive analyses.

Video coding: The doctor-patient encounter is coded for quality of SDM using either the OPTION instrument [38] or more likely the MAPPIN'SDM instrument [32], and The Four Habits Coding Scheme [34]. The doctor's use of specific intervention techniques is measured in frequencies and seconds (main explanatory variable). The adherence of the doctor to the priority facts in the fact sheet is measured on a novel scale developed for this purpose (confounding variable). We have not found any similar measure in the relevant literature that could be used for our purpose. We currently perform a qualitative study on existing video material from AHUS, led by postdoc Jennifer Gerwing (see study resources). In that study we identify communication content and clarity in doctor information giving. Her expertise will inform the development of the proposed scale.

Analysis: We will use a standard RCT to determine effect of the intervention, with multilevel approach accounting for interdependency between encounters made by the same doctor. We will also do a secondary analysis using standard linear regressions to determine predictors of patient post-encounter knowledge agreement with fact sheet, and predictors of adherence of the doctors to the prescribed behaviour.

Outcome variables in RCT:

1. The main outcome variable is a measure of patient knowledge about crucial information (as predefined by the fact sheet). The RIKNOW questionnaire, or an adjustment of this (following agreement about contents of the fact sheet), will be used. In addition, as a validity check, the patient's knowledge of prioritized facts is compared to the fact sheet on a scale (5-point from no agreement to high agreement) by a statistician that does not know which arm the data comes from.

2. Other outcome variables

    a. Patient evaluation of ability to be involved in the decision

    b. Patient satisfaction with the doctor's communication about the decision

Of note, we will not perform pre-encounter knowledge tests of the patients, as this could influence the encounters. Randomisation should in principle secure that this does not bias the results.

Publications from study 2: Two publications planned to be published. The effect study will be submitted to a major clinical journal. The study about doctor adherence to the fact sheet will be submitted to a journal about medical education or communication.

Secondary analyses: We aim to publish 1-2 papers on predictors of change.

Timeline, ethics, etc.

2014 The ethics committee application will be prepared and submitted before the start of the funding applied for in this proposal.

2015 Prepare electronic questionnaires. Prepare measurement scales and fact sheet. Recruitment for study 1 and study 1 data collection. Preparations for study 2.

2016 Submit paper from study 1.Study 2 data collection, videotape coding and starting analyses of study 2.

2017 Submit papers from study 2.Beginning secondary analysis. Submit thesis.

The study may extend into 2018 depending on recruitment of the PhD candidate.

Contribution to science and society

Experimental studies on concrete, limited clinical communication behaviours, specifically aimed at improving patients' understanding and thereby helping their involvement in decisions, have previously not been conducted. We hope this approach will lead to better insight in the direct link between information giving skills and information transfer in clinical work. We also aim to provide a new way of thinking in communication skills studies, with experimental studies preceding clinical trials, thereby bringing this field closer to the level of drug testing.

Decisions about long-term treatment have the potential to consume or save resources as the drug regimens may amount to high costs. It is not only in the patient's and the doctor's interest, but also in the interest of the society that these decisions are made as properly as possible.

Study group and resources

Principal investigator: Pål Gulbrandsen is professor of health services research at the University of Oslo (UiO) and AHUS, and has published more than 80 original papers, mostly on the doctor-patient relationship and doctor-patient communication. He has built a research group at AHUS with one completed PhD (plus two in other clinical areas) and three current PhD students studying clinical communication. He also initiated, with professor Arnstein Finset at Dept. of Behavioural Sciences (UiO), the Oslo Communication in Healthcare Education and Research group (OCHER, see www.ocher.no), which is the second largest group in the field in Europe.

Trygve Holmøy is a consultant and professor at Department of Neurology at AHUS. His main research interest is multiple sclerosis. He has supervised five PhD students that have completed their PhD theses during the last years, and has large experience with treating MS patients. He has participated extensively in the development of this project. He will participate in recruitment of patients and doctors, and co-supervise the PhD student.

Fredrik A. Dahl is a senior researcher at AHUS with a PhD in informatics and a postdoctoral in statistics. He has been an important contributor to several clinical studies in AHUS included a previous crossover randomised controlled trial testing the effect of communication skills training. He will supervise the statistical analysis and qualify the randomization procedures. He will have an important role in the secondary analyses, in which the PhD student is not expected to be the first author.

Jennifer Gerwing is a research psychologist and a postdoctoral student at AHUS. She is also affiliated with the University of Victoria, Canada, and has extensive experience with lab studies on clinical communication. She will supervise the video analyses.

External collaborators

Jürgen Kasper is professor at the University of Tromsø and an experienced psychologist with several years of studies of medical decision making. He is an important collaborator in the project "Autonomy preferences, risk knowledge and decision-making performance in multiple sclerosis patients". His contribution will be his knowledge base in this particular field.

Edward Krupat is professor of evaluation at Harvard Medical School, Boston, US. He is a social psychologist with large expertise in development of instruments for the evaluation of behaviours, and a collaborator of Pål Gulbrandsen for nine years. He will assist the development of measurements.

Kjell-Morten Myhr has for several years headed the Norwegian Competence Center for Multiple Sclerosis at Haukeland University Hospital, where he now is a full professor and consultant in neurology. He has extensive experience in MS research and clinical practice, including clinical trials. He has headed the development of official Norwegian guidelines for treatment of MS. He will participate in development of the fact sheet and in interpretation of the data.

Reidun Førde is a professor in medical ethics at the University of Oslo and has for years worked with problems related to the involvement of patients in decisions about treatment. She will assist in development of the fact sheet.

The expertise of all people mentioned above will be used in the project. The current proposal aims to fund one PhD student, preferably a medical doctor, to run the data collection and deliver a following thesis. This student will be recruited by public announcement.

Costs

AHUS covers expenses related to all listed internal collaborators, estimated to about NOK 500,000 over 3 years. AHUS also covers traveling costs for proxy patients (estimated to max NOK 10,000), development of electronic data sheets (equivalent of 30 hours), and estimated costs related to time used for participating doctors (equivalent of 50 hours). No expenses are related to the external collaborators. However, there is need to employ video coders, and they need to be trained. We estimate the costs for this training to NOK 100,000. The PhD candidate should attend two international conferences annually (in Europe and the US), for which we estimate the average cost to be NOK 10,000, amounting to NOK 60,000.

At our disposal we have a new communication observation lab inside the hospital, with state of the art equipment delivered by Noldus Inc., Wageningen, the Netherlands. This equipment is provided by the Institute of Clinical Medicine at the University of Oslo. The Dept of Neurology at AHUS has a catchment area of 450,000 people and the responsibility of approximately 700 MS patients (the number of newly diagnosed patients in 2011 and 2012 were 35 and 51, respectively).

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37. Gulbrandsen P. Benth JS, Dahl FA, Jensen BF, Finset A, Hall JA. Specialist physicians' sensitivity to patient affect and satisfaction. Med Care 2012; 50: 290-3.

38. Elwyn G, Hutchings H, Edwards A, Rapport F, Wensing M, Cheung WY, Grol R. The OPTION scale: measuring the extent that clinicians involve patients in decision-making tasks. Health Expect 2005; 8: 34-42.

There is no named PhD candidate so this file is empty.

We will primarily recruit a resident neurologist as PhD candidate, alternatively a resident in another specialty.

Curriculum vitae Pål Gulbrandsen

Name:	Pål Gulbrandsen
Sex:	Male
Year of birth:	1955
Nationality:	Norwegian
Present position:	Professor health services research(University of Oslo)/ senior researcher (Akershus University Hospital)
Previous academic positions:	Associate professor (University of Oslo)
Academic degree (university and year):	MD University of Bergen 1979, Dr. med. (PhD) University of Oslo 1998

Medical training and work:
In the period 1981-1994 I worked the equivalent of 12 years in general practice. I was a certified specialist in general practice 1991-2001. From 1983-1988 I also held public health positions, and I have been a certified specialist in public health since 1992. In 1990-1991 I worked the equivalent of 14 months in psychiatry. In the late 1990s I was physician-on-call for a centre for reception of victims of violence and/or rape (about 30 clients handled).

Communication skills training and work:
I participated in courses led by leading communication researchers David Pendleton, Theo Schofield, and Peter Havelock (Bergen, 1984), Jonathan Silverman (Asker, 1997), and Richard Frankel, Edward Krupat, and Dana G. Safran (Lørenskog, 2006) as well as all seminars arranged by the University of Oslo cross-faculty clinical communication project led by Arnstein Finset (1996-2000).

In general practice, I implemented communication skills according to Pendleton et al (1984) and Beckman & Frankel (1984). After the year in psychiatry, where I primarily learnt group therapy and broadened my knowledge about psychology, psychosomatic disorders, and role of the therapist, I also implemented these skills in my practice.

I have planned and led post-graduate teaching of clinical communication on several occasions (1990-2005) as part of the mandatory basic courses for general practitioners. My PhD thesis (1994-98) was on social context in general practice and implied studies of the physician-patient relationship and information exchange. Since 2006 my primary research and teaching field has been clinical communication skills and training.

Scientific review work including peer-review:
PhD evaluation committees University of Bergen (2012), University of Southern Denmark (2011), Gothenburg University (2006), University of Oslo (2006, 2006, 2009, 2010), professional evaluation for academic positions at The Norwegian University for Science and Technology (NTNU)(2012), University of Oslo (2011), Warwick Medical School (2008), Høgskolen i Haugesund (2007), four years as deputy editor Tidsskrift for Den norske lægeforening (The Journal of The Norwegian Medical Association), referee for more than ten journals including the BMJ.

Dissemination activities:
31 editorials Tidsskrift for Den norske legeforening, 47 book reviews, 20 essays, six of these in Norwegian main newspapers, almost 50 other commentaries etc. in journals for health professionals, more than 150 invited lectures for health professionals, politicians, officials, and the general public.

Research and research collaboration:
My main fields have been physician-patient relations and communication. Due to my general knowledge of a variety of research methods, I have also contributed to several epidemiological and clinical studies, which explains the rather varied publication list.

As can be seen from the list of publications, I have extensive international collaboration. My main partners have been Edward Krupat, Harvard Medical School, Richard M Frankel, Indiana University School of Medicine, Dana G. Safran, Tufts University, Judy Hall, Northeastern University, Kathryn Pollak and coworkers, Duke University, and Danielle Blanch-Hartigan, National Cancer Institute, all USA. I have also published with Even Lærum and coworkers at the University of Southern Denmark. I function as international expert in a large communication skills training and research project in Cologne, Germany, and I have contributed to a knowledge translation bid to the Canadian Research Council which received funding.

In Norway collaboration partners in research include among others Arnstein Finset, Department of Behavioural Sciences, Jan Svennevig, Institute of Linguistic and Scandinavian studies, and Reidun Førde, Center for Medical Ethics, all at the University of Oslo, Olaf Aasland at the Research Institute of the Norwegian Medical Assocation, Edvin Schei at the University of Bergen, and Kari Agledahl and Åge Wifstad at the University of Tromsø.

Supervision of PhD-students
- 4 PhD-students presently under supervision as main supervisor
- 3 PhD-students completed for the period 1.1.2005 - 1.2.2013 as main supervisor
- Co-supervisor of six completed PhDs and two current PhD students

Other professional merits:
Invited lectures: International Forum on Quality and Safety in Healthcare, Paris (2014), University of Southern Denmark (2014), Uppsala University (2013), Universität zu Köln/Private Universität Witten/Herdecke (2010, 2014) and University of York, School of Management (2009), Universitetet i Tromsø (2010, 2014). Advisor for the Norwegian Directorate of Health and the Norwegian Ministry of Health.

Affiliation in academic and professional committees:
Member of the Steering committee in European Association of Communication in Healthcare since 2010. Member of the tEACH subgroup of this organization.

Awards:
Best paper Sep-Dec 2010, Akershus University Hospital. Four essay awards in the Norwegian journal Utposten (for general practice and public health)

Grants:
I have received 15.2 mill NOK as principal investigator, and been collaborator in several other grants, of which two were major grants.

2008-2014 publications

- 44 publications in peer-reviewed journals or peer-reviewed monographs

Total career publications

- 81 publications in peer-reviewed journals or peer-reviewed monographs
- 17 review articles and book chapters

Original papers last 5 years (reverse chronology)

1. Hall JA, Gulbrandsen P, Dahl FA. Physician gender, physician patient-centered behavior, and patient satisfaction: A study in three practice settings within a hospital. Patient Educ Couns 2014; 95: 313-8. http://dx.doi.org/10.1016/j.pec.2014.03.015.
2. Gulbrandsen P. A matter of the heart. Patient Educ Couns 2014 Mar 19. http://dx.doi.org/10.1016/j.pec.2014.03.011.
3. Stensrud TL, Gulbrandsen P, Mjaaland TA, Skretting S, Finset A. Improving communication in general practice when mental health issues appear: Piloting a set of six evidence-based skills. Patient Educ Couns 2013 Dec 14. pii: S0738-3991(13)00519-3. doi: 10.1016/j.pec.2013.12.005. [Epub ahead of print]
4. Lauritzen PM, Hurlen P, Sandbæk G, Gulbrandsen P. Double reading rates and quality assurance practices in Norwegian hospital radiology departments: two parallel national surveys. Acta Radiol 14.1.2014 (DOI: 10.1177/0284185113519988). [Epub ahead of print]
5. Gjersvik P, Gulbrandsen P, Aasheim ET, Nylenna M. Dårlig tittel – dårlig manus? Tidsskr Nor Legeforen 2013; 133: 2475-7.
6. Gulbrandsen P, Fossli Jensen B, Finset A, Blanch-Hartigan D. Long-term effect of communication training on the relationship between physicians' self-efficacy and performance. Patient Educ Couns 2013; 91: 180-5.
7. Sundling V, Gulbrandsen P, Straand J. Sensitivity and specificity of Norwegian optometrists' evaluation of diabetic retinopathy in single-field retinal images. BMC Health Serv Res 2013 Jan 10; 13: 17.
8. Randsborg PH, Gulbrandsen P, Sivertsen EA, Hammer OL, Fuglesang H, Šaltytė Benth J, Årøen A. Fractures in children. Epidemiology and activity-specific fracture rates. J Bone Joint Surg Am 2013; 95(7):e42. doi: 10.2106/JBJS.L.00369.
9. Sundling V, Platou CG, Jansson RW, Bertelsen G, Wøllo E, Gulbrandsen P. Retinopathy and visual impairment in diabetes, impaired glucose tolerance and normal glucose tolerance: The Nord-Trøndelag Health Study (the HUNT study). Acta Ophtalmol 2012; 90: 237-43.
10. Gulbrandsen P, Benth JS, Dahl FA, Jensen BF, Finset A, Hall JA. Specialist physicians' sensitivity to patient affect and satisfaction. Med Care 2012; 50: 290-3.
11. Steihaug S, Werner A, Gulbrandsen P. Recognition can leave room for disagreement in the doctor-patient consultation. Patient Educ Couns 2012; 86: 316-21.
12. Gulbrandsen P, Østbye T, Lyna P, Dolor RJ, Tulsky JA, Alexander SC, Pollak KI. The influence of physician communication style on overweight patients' perception of length of encounter and physician being rushed. Fam Med 2012; 44: 183-8.
13. Hurlen P, Borthne AS, Dahl FA, Østbye T, Gulbrandsen P. Does PACS improve diagnostic accuracy in chest radiograph interpretations in clinical practice? Eur J Radiol 2012; 81: 173-7.
14. Pollak KI, Coffman CJ, Alexander SC, Tulsky JA, Lyna P, Dolor RJ, Cox ME, Brouwer RJN, Gulbrandsen P, Østbye T. Physician empathy and listening: Associations with patient satisfaction and autonomy. J Am Board Fam Med 2011; 24: 665-72.
15. Mjaaland TA, Finset A, Fossli Jensen B, Gulbrandsen P. Patients' negative emotional cues and concerns in hospital consultations: A video-based observational study. Patient Educ Couns 2011; 85: 356-62.
16. Agledahl K, Wifstad Å, Førde R, Gulbrandsen P. Courteous but not curious: How doctors' politeness masks their existential neglect. A qualitative study of video-recorded patient consultations. J Med Ethics 2011, 37; 650-4.

17. Fossli Jensen B, Dahl FA, Safran DG, Garratt AM, Krupat E, Finset A, Gulbrandsen P. The ability of a behaviour specific questionnaire to identify poorly performing doctors. BMJ Qual Saf 2011; 20: 885-93.
18. Mjaaland TA, Finset A, Fossli Jensen B, Gulbrandsen P. Physicians' responses to patients' negative emotions in hospital consultations: A video-based observational study. Patient Educ Couns 2011; 84: 332-7.
19. Kale E, Finset A, Eikeland H-L, Gulbrandsen P. Emotional cues and concerns in hospital encounters with non-Western immigrants as compared with Norwegians. An exploratory study. Patient Educ Couns 2011; 84: 325-31.
20. Fossli Jensen B, Gulbrandsen P, Dahl FA, Krupat E, Frankel RM, Finset A. Effectiveness of a short course in clinical communication skills for hospital physicians: results of a crossover randomized controlled trial (ISRCTN22153332). Patient Educ Couns 2011; 84; 163-9.
21. Garratt AM, Helgeland J, Gulbrandsen P. Five-point scales outperform 10-point scales in a randomized comparison of item scaling for the Patient Experiences Questionnaire. J Clin Epidemiol 2011: 64: 200-7.
22. Hurlen P, Østbye T, Borthne A, Gulbrandsen P. Does improved access to diagnostic imaging results reduce hospital length of stay? A retrospective study. BMC Health Serv Res 2010; 10: 262.
23. Fossli Jensen B, Gulbrandsen P, Dahl FA, Saltyte-Benth J, Krupat E, Finset A. The interrater reliability of the Four Habits Coding Scheme as part of a randomized controlled trial. Patient Educ Couns 2010; 80: 405-9.
24. Gulbrandsen P, Madsen HB, Benth JS, Lærum E. Health care providers communicate less well with patients with chronic low back pain – A study of encounters at a back pain clinic in Denmark. Pain 2010; 150: 458-61.
25. Bø SH, Davidsen EM, Benth JS, Gulbrandsen P, Dietrichs E. The usefulness of testing head and neck muscle tenderness and neck mobility in acute headache patients. Funct Neurol 2010; 25: 27-31.
26. Bø SH, Dietrichs E, Davidsen EM, Gulbrandsen P. CSF opening pressure measurements in acute headache patients compared to patients with either chronic or no pain. Acta Neurol Scand Suppl 2010; 190: 6-11.
27. Randsborg P-H, Sivertsen EA, Skråmm I, Benth JS, Gulbrandsen P. The need for better analysis of observational studies in orthopedics. A retrospective study of elbow fractures in children. Acta Orthop 2010; 81: 377-81.
28. Østerås N, Gulbrandsen P, Kann IC, Brage S. Structured functional assessments in general practice increased the use of part-time sick leave: a randomised controlled trial. Scand J Public Health 2010; 38: 192-9.
29. Hurlen P, Østbye T, Borthne A, Gulbrandsen P. Introducing PACS to the late majority. A longitudinal study. J Digit Imaging 2010; 23: 87-94.
30. Gulbrandsen P, Fossli Jensen B. Post recruitment confirmation of informed consent by SMS. J Med Ethics 2010; 36: 126-8.
31. Gulbrandsen P, Fossli Jensen B, Finset A. Endring i mestringstillit hos sykehusleger etter kurs i klinisk kommunikasjon. Tidsskr Nor Legeforen 2009; 129: 2343-6. [English version available (http://tidsskriftet.no/lts-pdf/pdf2009/2343-6eng.pdf)]
32. Østerås N, Gulbrandsen P, Benth JS, Hofoss D, Brage S. Implementing structured functional assessments in general practice for persons with long-term sick leave: a cluster randomised controlled trial. BMC Family Practice 2009; 10: 31.
33. Grande RB, Aaseth K, Saltyte-Benth J, Gulbrandsen P, Russell MB, Lundqvist C. The severity of dependence scale detects people with medication overuse. The Akershus study of chronic headache. J Neurol Neurosurg Psychiatry 2009; 80: 784-9.
34. Hurlen P, Østbye T, Borthne A, Dahl FA, Gulbrandsen P. Do clinicians read our reports? Integrating the Radiology Information System with the Electronic Patient Record – Experiences from the first two years. Eur Radiol 2009; 19. 31-6.
35. Mjåset C, Gulbrandsen P, Rønning OM, Thommessen B. Før og etter HLR minus-vedtak – en deskriptiv studie fra en slagenhet. Tidsskr Nor Legeforen 2008; 128: 2819-22.

36. Bø SH, Davidsen E, Gulbrandsen P, Dietrichs E, Bovim G, Stovner L, White L. Cerebrospinal fluid cytokine levels in migraine, tension-type headache, and cervicogenic headache. Cephalalgia 2008; 29: 365-72..
37. Bø SH, Davidsen EM, Gulbrandsen P, Dietrichs E. Acute headache: A prospective diagnostic work-up of patients admitted to a general hospital. Eur J Neurol 2008; 15: 1293-9.
38. Gulbrandsen P, Krupat E, Saltyte Benth J, Garratt A, Safran DG, Finset A, Frankel R. "Four habits" goes abroad – report from a pilot study in Norway. Patient Educ Couns 2008; 72: 388-93.
39. Sundling V, Gulbrandsen P, Jervell J, Straand J. Care of vision and ocular health in diabetic members of a national diabetes association: a cross-sectional study. BMC Health Serv Res 2008: 8: 159.
40. Aaseth K, Grande RB, Kværner KJ, Gulbrandsen P, Lundqvist C, Russell MB. Prevalence of secondary chronic headaches in a population-based sample of people 30-45 years. Cephalalgia 2008; 28: 705-13.
41. Østerås N, Gulbrandsen P, Garratt A, Benth JS, Dahl FA, Natvig B, Brage S. A randomised comparison of a four- and a five-point scale version of the Norwegian Function Assessment Scale. Health Qual Life Outcomes 2008; 6: 14.
42. Lossius MI, Hessen E, Stavem K, Erikssen J, Mowinckel P, Gulbrandsen P, Gjerstad L. Consequences of antiepileptic drug withdrawal – a randomised double-blind study (The Akershus withdrawal study). Epilepsia 2008; 49: 455-63.
43. Grande RB, Aaseth K, Gulbrandsen P, Lundqvist C, Russell MB. Prevalence of primary chronic headache in a population-based sample of 30-44 year old persons. The Akershus study of chronic headache. Neuroepidemiology 2008; 30: 76-83.
44. Sundling V, Gulbrandsen P, Bragadottir R, Bakketeig LS, Jervell J, Straand J. Suspected retinopathies in Norwegian optometric practice with emphasis on patients with diabetes: a cross-sectional study. BMC Health Serv Res 2008; 8: 38.

Other scientific contributions last 5 years

1. Gulbrandsen P. Klinisk kommunikasjon i sykehus – et skrikende forbedringsbehov. I Johnsen K, Engvold HO, red. Klinisk kommunikasjon i praksis. Oslo: Universitetsforlaget, 2013: 102-12.
2. Gulbrandsen P. Kunnskap over hodet eller til hjertet: Legen som forvalter og formidler. I: Larsen Ø, Fretheim A, Larsen IF, Westin S, red. Hva er medisinsk kunnskap? Festskrift til Magne Nylennas 60-årsdag. Oslo: Gyldendal Akademisk, 2012: 249-58.
3. Gulbrandsen P. Å gi informasjon om sårbarhet. Tidsskr Nor Legeforen 2012; 132: 2034.
4. Frich JC, Gran SF, Vandvik PO, Gulbrandsen P, Hjortdahl P. Kunnskap, ledelse og kvalitet i studiet. Tidsskr Nor Legeforen 2012; 132: 1768-70.
5. Gulbrandsen P. Kan vi oppnå dannede leger? Om mottrekk mot objektivering og større rom for åpenhet, nysgjerrighet og refleksjon i medisinstudiet. I Hagtvet B, Ognjenovic G, red. Tenkning, modning, refleksjon. Oslo; Dreyer, 2011: 427-37.
6. Gulbrandsen P. Informasjon må individualiseres. Tidsskr Nor Legeforen 2010; 130: 2336.
7. Gulbrandsen P. God kommunikasjon – også for legenes skyld! Tidsskr Nor Legeforen 2008; 128: 2840-2.

In addition more than 25 scientific abstracts and 9 book reviews for Tidsskrift for Den norske legeforening.

Publikasjonsliste – Pål Gulbrandsen
per 15. mai 2014

A. Originale vitenskapelige publikasjoner i tidsskrifter med refereetjeneste
Titler i kursiv er sekundærpublikasjoner (i alt 3)

1. Hall JA, Gulbrandsen P, Dahl FA. Physician gender, physician patient-centered behavior, and patient satisfaction: A study in three practice settings within a hospital. Patient Educ Couns 2014; 95: 313-8. http://dx.doi.org/10.1016/j.pec.2014.03.015.
2. Gulbrandsen P. A matter of the heart. Patient Educ Couns 2014 Mar 19. http://dx.doi.org/10.1016/j.pec.2014.03.011.
3. Stensrud TL, Gulbrandsen P, Mjaaland TA, Skretting S, Finset A. Improving communication in general practice when mental health issues appear: Piloting a set of six evidence-based skills. Patient Educ Couns 2013 Dec 14. pii: S0738-3991(13)00519-3. doi: 10.1016/j.pec.2013.12.005. [Epub ahead of print]
4. Lauritzen PM, Hurlen P, Sandbæk G, Gulbrandsen P. Double reading rates and quality assurance practices in Norwegian hospital radiology departments: two parallel national surveys. Acta Radiol 14.1.2014 (DOI: 10.1177/0284185113519988). [Epub ahead of print]
5. Gjersvik P, Gulbrandsen P, Aasheim ET, Nylenna M. Dårlig tittel – dårlig manus? Tidsskr Nor Legeforen 2013; 133: 2475-7.
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8. Sundling V, Gulbrandsen P, Straand J. Sensitivity and specificity of Norwegian optometrists' evaluation of diabetic retinopathy in single-field retinal images. BMC Health Serv Res 2013; 13: 17.
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15.Mjaaland TA, Finset A, Fossli Jensen B, Gulbrandsen P. Patients' negative emotional cues and concerns in hospital consultations: A video-based observational study. Patient Educ Couns 2011; 85: 356-62.
16.Agledahl K, Wifstad Å, Førde R, Gulbrandsen P. Courteous but not curious: How doctors' politeness masks their existential neglect. A qualitative study of video-recorded patient consultations. J Med Ethics 2011, 37; 650-4.
17.Fossli Jensen B, Dahl FA, Safran DG, Garratt AM, Krupat E, Finset A, Gulbrandsen P. The ability of a behaviour specific questionnaire to identify poorly performing doctors. BMJ Qual Saf 2011; 20: 885-93.
18.Mjaaland TA, Finset A, Fossli Jensen B, Gulbrandsen P. Physicians' responses to patients' negative emotions in hospital consultations: A video-based observational study. Patient Educ Couns 2011; 84: 332-7.
19.Kale E, Finset A, Eikeland H-L, Gulbrandsen P. Emotional cues and concerns in hospital encounters with non-Western immigrants as compared with Norwegians. An exploratory study. Patient Educ Couns 2011; 84: 325-31.
20.Fossli Jensen B, Gulbrandsen P, Dahl FA, Krupat E, Frankel RM, Finset A. Effectiveness of a short course in clinical communication skills for hospital physicians: results of a crossover randomized controlled trial (ISRCTN22153332). Patient Educ Couns 2011; 84; 163-9.
21.Garratt AM, Helgeland J, Gulbrandsen P. Five-point scales outperform 10-point scales in a randomized comparison of item scaling for the Patient Experiences Questionnaire. J Clin Epidemiol 2011: 64: 200-7.
22.Hurlen P, Østbye T, Borthne A, Gulbrandsen P. Does improved access to diagnostic imaging results reduce hospital length of stay? A retrospective study. BMC Health Serv Res 2010; 10: 262.
23.Fossli Jensen B, Gulbrandsen P, Dahl FA, Saltyte-Benth J, Krupat E, Finset A. The interrater reliability of the Four Habits Coding Scheme as part of a randomized controlled trial. Patient Educ Couns 2010; 80: 405-9.
24.Gulbrandsen P, Madsen HB, Benth JS, Lærum E. Health care providers communicate less well with patients with chronic low back pain – A study of encounters at a back pain clinic in Denmark. Pain 2010; 150: 458-61.
25.Bø SH, Davidsen EM, Benth JS, Gulbrandsen P, Dietrichs E. The usefulness of testing head and neck muscle tenderness and neck mobility in acute headache patients. Funct Neurol 2010; 25: 27-31.
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B. Andre vitenskapelige publikasjoner med originalt innhold

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C. Oversiktsartikler, reviews, bokkapitler, synopsis m.m.

1. Gulbrandsen P. Klinisk kommunikasjon i sykehus – et skrikende forbedringsbehov. I Johnsen K, Engvold HO, red. Klinisk kommunikasjon i praksis. Oslo: Universitetsforlaget, 2013: 102-12.
2. Gulbrandsen P. Kunnskap over hodet eller til hjertet: Legen som forvalter og formidler. I: Larsen Ø, Fretheim A, Larsen IF, Westin S, red. Hva er medisinsk kunnskap? Festskrift til Magne Nylennas 60-årsdag. Oslo: Gyldendal Akademisk, 2012: 249-58.
3. Gulbrandsen P. Kan vi oppnå dannede leger? Om mottrekk mot objektivering og større rom for åpenhet, nysgjerrighet og refleksjon i medisinstudiet. I Hagtvet B, Ognjenovic G, red. Tenkning, modning, refleksjon. Oslo; Dreyer, 2011: 427-37.
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D. Populærvitenskapelige arbeider for det alminnelige publikum

1. Gulbrandsen P. Hoste. I: Fugelli P, red. Flexikon. Bind 7: Medisinsk leksikon fra A til Å. Oslo: Arnkrone AS Nordiske Bokverk, 1990; 128
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E. Abstract av foredrag, seminar m.v. som inneholder originalmateriale, og som ikke er offentliggjort på annen måte

1. Gulbrandsen P, Ofstad EH, Dalby AML. Confusion in and about shared decision making. Oral presentation. International Conference on Communication in Healthcare, Montreal, Canada, 29 Sep- 2 Oct 2013.
2. Gjersvik P, Nylenna M, Gulbrandsen P, Aasheim E. Poor manuscript title as a predictor for manuscript rejection in a general medical journal: a cohort study. Peer Review Congress, Chicago, September 2013.
3. Steinhausen S, Vitinius F, Ommen O, Wilm S, Pfaff H, Bödecker A-W, Gulbrandsen P, Neugebauer E. Development and feasibility of a "Four Habits"-based communication training for German General Practitioners (CoTrain). European Association of Psychosomatic Medicine conference, Cambridge, 4-6 July 2013.
4. Sundling V, Gulbrandsen P, Straand J. Detection of diabetic retinopathy by Norwegian community optometrists – a cross-sectional experimental study. Diabetesforskningskonferansen, Oslo, 15-16 november 2012.
5. Ofstad E, Frich JC, Schei E, Gulbrandsen P. Doctors' statements conveying clinical decisions. Accepted as oral presentation, European Association for Communication in Healthcare, St. Andrews, 4-7 September 2012.
6. Gulbrandsen P, Benth JS. Patients' emotions before and after hospital encounters in different settings. Accepted as oral presentation, European Association for Communication in Healthcare, St. Andrews, 4-7 September 2012.
7. Steinhausen S, Ommen O, Wilm S, Vitinius F, Pfaff H, Boedecker A, Gulbrandsen P, Neugebauer E. Development and feasibility of a "Four Habits"-based communication training for German general practitioners – CoTrain. Accepted as poster, European Association for Communication in Healthcare, St. Andrews, 4-7 September 2012.
8. Dalby AML, Svennevig J, Gulbrandsen P. Dealing with minimal response from patients. Accepted as oral presentation, European Association for Communication in Healthcare, St. Andrews, 4-7 September 2012.
9. Dalby AML, Svennevig J, Gulbrandsen P. Interaction strategies in decision making with patient resistance. Accepted as oral presentation, 10th Interdisciplinary Conference on Communication, Medicine and Ethics, Trondheim, 28-30 June, 2012.

10. Ofstad EH, Frich JC, Schei E, Gulbrandsen P. What goes on in hospitals? Identification, classification, and distribution of clinical decisions in hospital encounters. Accepted as poster, Biennial meeting of the European Society for Medical Decision Making, Oslo, 10-12 June, 2012.
11. Ofstad EH, Frich JC, Schei E, Finset A, Gulbrandsen P. Development of a tool for identification and classification of decisions in medical encounters. Accepted as poster, Annual meeting of Society for Medical Decision Making, Chicago, 23-26 October, 2011.
12. Ofstad EH, Frich JC, Schei E, Finset A, Gulbrandsen P. Towards a typology of decisions to explore how communication influences clinical outcome. Accepted as poster, International Conference on Communication in Healthcare, Chicago, 16-19 October, 2011.
13. Ofstad EH, Scholl I, Elwyn G, Braddock 3rd CH, Gulbrandsen P, Makoul G. Measuring shared decision making. Review of measures and developments in the field. Accepted as symposium, International Conference on Communication in Healthcare, Chicago, 16-19 October, 2011.
14. Agledahl K, Gulbrandsen P, Førde R, Wifstad Å. Handle with care: A qualitative study of video-recorded patient consultations. Abstract, konferansen Nursing under northern lights, Hammerfest, 30. september-1. oktober 2010
15. Janssen C, Lefering R, Ommen O, Bouillon B, Neugebauer E, Tecic T, Thüm S, Moser K, Gulbrandsen P, Pfaff H. Advanced Trauma Psychosocial Support (ATPS) – ein umfassender Konzept zur Verbesserung der Arzt-Patient-Interaktion in der Unfallchirurgie. Oral presentation and poster. Gemeinsamer Kongress der Deutschen gesellschaft für Medizinische Psychologie und der Deutschen Gesellschaft für Medizinische Soziologie. Giessen, 15-18. september 2010.
16. Agledahl K, Gulbrandsen P, Førde R, Wifstad Å. Taking care of patients: A study of video-recorded patient consultations. Accepted as oral presentation, European Association of Centres of Medical Ethics (EACME), Oslo, 8-10 september 2010.
17. Pollak KI, Alexander SC, Tulsky JA, Dolor RJ, Lyna P, Coffman CJ, Cox ME, Brouwer RJN, Gulbrandsen P, Østbye T. Physician use of MI techniques and patient satisfaction and autonomy support. Accepted as oral presentation. AACH Conference, Scottsdale, Arizona, 15-17 oktober 2010.
18. Mjaaland TA, Eikeland HL, Ørnes K, Gulbrandsen P, Kale E, Finset A et al. Cues and concerns in general hospital settings. Symposium on communication and education. EACH conference, Verona, Italia, 5-8 september 2010
19. Gulbrandsen P, Fossli Jensen B, Finset A. Gender dyads and communication quality in hospitals. Accepted as oral presentation. EACH Conference, Verona, Italia, 5-8 september
20. Gulbrandsen P, Østbye T, Alexander SC, Pollak KI. Patient and physician perception of duration of office consultations. Accepted as oral presentation. EACH Conference, Verona, Italia, 5-8 september 2010
21. Gulbrandsen P. Development of a typology of decisions in medical encounters. Accepted as poster. SMDM, 13th European meeting, Hall, Østerrike, 30 May-2 June, 2010.
22. Gulbrandsen P, Fossli Jensen B, Bjarke Madsen H, Lærum E, Janssen C, Finset A, Krupat E, Frankel R. ”Four habits” translation to different clinical cultures and countries. Accepted as symposium. International Conference on Communication in Healthcare, Miami, Florida, 4-7 October, 2009.
23. Bouillon B, Gulbrandsen P, Janssen C, Moser K, Neugebauer E, Pfaff H, Schneider A, Thuem S. A communication training program in trauma surgery as a part of "Advanced

Trauma Psychosocial Support (ATPS). Accepted as oral presentation. International Conference on Communication in Healthcare, Miami, Florida, 4-7 October, 2009.

24. Finset A, Fossli Jensen B, Gulbrandsen P, Krupat E. Application of the Four Habits Coding Scheme in coding communication across all clinical settings in a hospital in Norway. Accepted as poster. International Conference on Communication in Healthcare, Miami, Florida, 4-7 October, 2009.
25. Fossli Jensen B, Gulbrandsen P, Kristvik E, Finset A. Experiences with a randomised controlled trial of the effect of teaching clinical communication across specialties in one hospital. Accepted as oral presentation. European Association of Communication in Healthcare 4th International Conference, Oslo, 2-5 september 2008.
26. Gulbrandsen P, Frankel RM, Krupat E, Fossli Jensen B, Finset A. Experiences with the application of the Four Habits Model in Norway. Accepted as workshop. European Association of Communication in Healthcare 4th International Conference, Oslo, 2-5 september 2008.
27. Dahl FA, Gulbrandsen P. Eliciting decision weights from clinicians. 28th annual meeting, Society of Medical Decision Making, Boston, Massachusetts, oktober 2006.
28. Dahl FA, Gulbrandsen P. IT-based experience support for clinicians. Poster, Society for Medical Decision Making, 10th Biennial European Conference, Birmingham, 11-13.6.2006.
29. Gulbrandsen P, Lurås H, Vendshol TM. A study of the integration of a primary care emergency ward and a hospital emergency unit. Socialmedicinsk tidskrift 2006, bilaga: 129.
30. Gulbrandsen P. Do doctors' attitudes towards patients and opinions about social welfare change with time? Eur J Publ Health 2003; 13 (Supplement 4): 95. Abstract.
31. Gulbrandsen P. Assuring the quality of general practitioners' work with psychosocial problems: Some experiences. Zürich: The 1st Open EQuiP Conference on Quality Improvement in Family Practice, 1997: 65.
32. Gulbrandsen P. Kvalitetssikring av allmennpraktikernes arbeid med psykososiale problemer. Oslo: Kvalitetssikringsfondenes erfaringsseminar, 1997.
33. Gulbrandsen P. The social context of patients - adequate accumulation and use of this knowledge. Stockholm: The 3rd European Congress on Family Medicine/General Practice, WONCA, 1996: 70.

F. Abstract med innhold som ellers er offentliggjort gjennom de vitenskapelige publikasjonene

1. Gulbrandsen P, Madsen HB, Benth JS, Lærum E. Health care providers communicate less well with chronic low back pain patients. Accepted as oral presentation. International Conference on Communication in Healthcare, Miami, Florida, 4-7 October, 2009.
2. Gulbrandsen P. Krupat E, Garratt A, Benth JS, Safran D, Frankel R, Finset A. Development of a questionnaire to observe "Four habits" specific physician behaviour. American Academy of Communication in Health Care 2007 Forum, Charleston, South Carolina, 9-12.10.2007 (accepted as oral presentation)
3. Gulbrandsen P, Finset A, Frankel R, Safran D, Krupat E, Benth JS, Garratt A. A pilot study of "Four habits" in Norway. American Academy of Communication in Health Care 2007 Forum, Charleston, South Carolina, 9-12.10.2007 (accepted as poster)

4. Grande RB, Aaseth K, Gulbrandsen P, Lundqvist C, Russell MB. Primary chronic headache in the general population. Nevrodagene, Oslo, november 2007.
5. Grande RB, Aaseth K, Gulbrandsen P, Russell MB, Lundqvist C. Probable chronic tension-type headache with medication overuse in the Norwegian general population. Nevrodagene, Oslo, november 2007
6. Aaseth K, Grande RB, Gulbrandsen P, Lundqvist C, Russell MB. Secondary chronic headache in the general population. Nevrodagene, Oslo, november 2007.
7. Aaseth K, Grande RB, Kværner KJ, Gulbrandsen P, Lundqvist C, Russell MB. Prevalence of secondary chronic headache in the general population.. International Headache Conference, Stockholm, juni/juli 2007. Prisbelønt: **1st prize best poster.**
8. Grande RB, Aaseth K, Gulbrandsen P, Lundqvist C, Russell MB. Chronic headache in a population based sample. International Headache Conference, Stockholm, 2007.
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Anbefaling

Denne anbefaling er skrevet fordi det er påkrevet at hovedveileder anbefaler en prosjektsøknad i søknadssystemet til Extrastiftelsen.

Det er imidlertid litt pussig å anbefale en prosjektsøknad jeg selv har ansvaret for.

Den aktuelle søknaden er først og fremst utarbeidet av undertegnede i tett samarbeid med professor Trygve Holmøy. Vi har per i dag ikke rekruttert noen doktorgradskandidat til prosjektet. Rekruttering vil sannsynligvis bli iverksatt i tilfelle bevilgning, men vi vil i mellomtiden se etter kandidater blant LIS-leger på Akershus universitetssykehus.

Hvis vi får midler er det jeg som kommer til å være hovedveileder. Prosjektet har vært planlagt lenge, og prosjektsøknaden har gjennomgått flere forbedringer det siste året. Vi mener vi har god kontroll på prosjektplanen og kostnadene, og at dette prosjektet vil være gjennomførbart.

Lørenskog, 15. mai 2014

Pål Gulbrandsen

Akershus universitetssykehus

UNIVERSITETET I OSLO

Ekstrastiftelsen

Anbefaling av søknad

Prosjektnavn: Improvement of shared decision making about treatment options with multiple sclerosis patients

Stipendiat: PhD-stipendiat vil bli rekruttert gjennom utlysning.

Hovedveileder: Pål Gulbrandsen

Ansvarlig institusjon: Jeg representerer både Akershus universitetssykehus (Ahus) og Universitetet i Oslo (UiO). Stipendiater hos oss blir normalt knyttet til UiO, men kan også knyttes til Ahus.

Postadresse: Forskningssenteret, Akershus universitetssykehus, Postboks 1000, 1478 Lørenskog
Administrativt ansvarlig person: Hilde Lurås

Det bekreftes at søknaden kan sendes inn i henhold til de betingelser som er gitt i retningslinjer og regler fra Extrastiftelsen. Ved en eventuell tildeling av midler påtar institusjonen seg arbeidsgiveransvar og stiller annen nødvendig infrastruktur til disposisjon.

Lørenskog, 15. mai 2014

Med vennlig hilsen

Hilde Lurås
Direktør for forskning og innovasjon

Postadresse:
Akershus universitetssykehus HF
1478 LØRENSKOG

Besøksadresse:
Sykehusveien 25
Nordbyhagen

Telefon: +47 02900
Telefaks: +47 67968861
E-post: postmottak@ahus.no

Bank: 6468.05.00949
Org.nr: 983 971 636
Web: www.ahus.no

HELSE SØR-ØST

UiO : Det medisinske fakultet
Universitetet i Oslo

Letter of confirmation

I hereby confirm that I will serve as a collaborator in the project "The choice is yours – communication about treatment options with multiple sclerosis patients".

Being a medical doctor and professor in medical ethics, patient communication, information sharing and the strengthening of the patient's voice in medical deicison making is my main research field. Increased knowledge within this field is also important in education of health care personell. The present project can add important knowledge in a field which so far has received too little attention in medical research and practice.

Hopefully my research competence and knowledge within clinical ethics can contribute to this important project.

Oslo May 15. 2014

Reidun Førde
MD. Professor

Senter for medisinsk etikk
Postadr.: Postboks 1130 Blindern, 0318 Oslo
Besøksadr.: Kirkeveien 166, Fredrik Holsts hus, 0450 Oslo

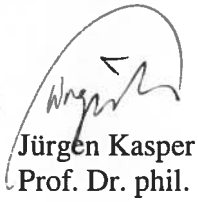
Telefon: 22 85 05 50
Telefaks: 22 85 05 90
postmottak@medisin.uio.no
www.med.uio.no/helsam
Org.nr.: 971 035 854

Declaration of collaboration intent

I have reviewed and participated in the process of producing this proposal, and I intend to be part of the study throughout.

Professor Pål Gulbrandsen has written that I am from Germany, which is right, but I just recently received an academic position at the Faculty of Health Sciences at the University of Tromsø, Norway and started there last week. I am fluent in German and English, and know Norwegian quite well, which is helpful in a study of communication in Norwegian health care.

Tromsø, 15. Mai 2014



Jürgen Kasper
Prof. Dr. phil.

Harvard Medical School

May 10, 2013

Dear Funding Committee:

I am writing this letter to express my enthusiasm for the project being proposed by Pal Gulbrandsen, and to indicate my intention to collaborate with his research group in this exciting project. I would hope to contribute to the overall design of the research, especially in the development of instrumentation, and to be in close touch with Pal during data collection, analysis, and interpretation. I bring 20+ years of background in research and study of the doctor-patient relationship and have developed instruments for its assessment that have been used internationally.

The utilization of an experimental design in the study of shared decision making is ground-breaking, and the improvement of care for multiple sclerosis via shared decision is very important. I look forward to working actively with Pal and the talented team he has put together.

Sincerely,

Edward Krupat, PhD
Director
HMS Center for Evaluation

Bergen, 15-MAY-2015

Professor Pål Guldbrandsen
University of Oslo / Akershus University Hospital
1478 LØRENSKOG - NORWAY

Letter of support - *"The choice is yours – communication about treatment options with multiple sclerosis patients"*

I hereby confirm my support and participation in this project aiming at improved communication during important decision processes of multiple sclerosis treatment. I will contribute with my experience of clinical trials and treatment of patients with multiple sclerosis.

Kind regards

Kjell-Morten Myhr, MD, PhD

Professor
The KG Jebsen Centre for MS-research,
Department of Clinical Medicine, University of Bergen &
The Norwegian Multiple Sclerosis Registry & Biobank
Department of Neurology, Haukeland University Hospital
Bergen, Norway