



Case stories in small-group activity in general practice. A focus group study from backstage

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4 **backstage**
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3 **Case stories in small-group activity in general practice. A focus group study from**
4 **backstage.**
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7 **Abstract**
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9 **Objectives** To explore the interactive process of sharing case stories in small-group activity in
10 general practice.
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12 **Design** Qualitative focus group study.

13 **Setting** Peer group meetings of doctors attending specialist training or continuous medical
14 education in general practice.
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16 **Participants** Twenty female and 30 male doctors working in general practice in Norway.

17 **Results** The storyline of case presentations included detailed stories with emotional
18 engagement, co-authored by other group members. The stories initiated discussions and
19 reflections concerning patients' and doctors' perspectives, medical ethics as well as clinical
20 problems. The safe atmosphere allowed testing out boundaries of socially shared knowledge.
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22 **Conclusions** Sharing case stories in small-groups in general practice initiated interaction that
23 facilitated meaning-making, reflection and peer support.
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27 **Article summary**
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29 Article focus
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- 31 • Sharing case stories have longstanding traditions among doctors. General practitioners
32 share case stories in small-group learning.
- 33 • Socially shared knowledge is formed and maintained through dialogical thinking and
34 communication, and affects what is being talked about and the manner by which
35 content is framed.
- 36 • We intended to explore the interactive process of discussing case stories in peer
37 groups of general practitioners.
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41 Key messages
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- 43 • Case presentations in focus groups included detailed stories with emotional
44 engagement and co-authoring from other group members.
- 45 • Group interaction initiated discussions about the patients' and doctors' behaviours and
46 agendas, ethical implications and the handling of clinical problems in everyday
47 practice.
- 48 • Case discussions inspired group members to reflect upon the complexity of
49 counselling and the doctors' roles. The participants offered each other critique and
50 peer support.
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55 Strengths and limitations
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- 57 • The presence of the researchers influenced what group members chose to tell.
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- Being a peer may cause blindness to aspects of the discussions that a researcher with different background would see.
- The participants discussed real case stories from their own practice.

Introduction

Case stories have longstanding traditions in medicine. Doctors share case stories when referring patients to hospital from primary health care, at morning reports in hospital, and when discussing interesting or difficult cases.^{1,2} Case stories include everyday practice, dramatic “war stories” and anecdotes of uncommon practice. The stories aim to provide a professional audience with succinct and sufficient information.³ Doctors adopt the medical storyline early in their career. During case presentations students, interns and residents improve knowledge based on clinical experience, and learn the medical language, professional principles, traditions and values.⁴ Their supervisors evaluate their presentations based on relevance, conciseness and mastery of the medical language.⁵ Patients adjust their illness narratives to the listening doctor,⁶ doctors adjust their retelling and interpretations into case stories suitable for a professional audience.⁷

Peer groups of general practitioners share professional competence, experience and social role. Socially shared knowledge has an interactive nature. It is formed and maintained through dialogical thinking and communication, and affects what is being talked about and the manner by which content is framed.⁸ It influences how group members speak about others, such as patients, other professionals or health authorities. Dialogues involve tension and intentions, and dealing with the implicit shared knowledge within a group is an important social skill.⁹ The distribution of this competence within a group may affect group dynamics, and the outcome of group discussions. Communication is affected by fear of losing face, indirect communication and hidden agendas. While group members talk to each other, they may simultaneously carry out internal dialogues with themselves or others.⁸

Research on the development of doctors’ communication patterns emphasizes that medical education, internship and residency influence doctors’ identities in ways that affect communication with patients.¹⁰ Case-based teaching is used along with problem-based teaching in medical education, and is well suited for small-group teaching.¹¹ Problem-based teaching focuses on a particular clinical problem, while case-based teaching focuses on a particular patient presenting with a clinical problem. In general practice case-based learning in organized peer groups is widely used.¹²⁻¹⁵ Permanent small-group activities have become an important part of CME in many countries, and if well functioning as supportive networks to share knowledge and clinical experience.¹⁶⁻¹⁹

The primary aim of the research project was to study general practitioners’ experience with lifestyle counselling. While conducting focus group sessions among general practitioners,²⁰ we observed interesting interaction within the groups, and decided to explore this interaction in detail. We have not identified studies that explore the interactive process of discussing case

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3 stories in peer groups of general practitioners, and aimed to do so in this paper.
4

5 6 **Methods**

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8 We invited seven established peer groups from the southern part of Norway to attend focus
9 group sessions on lifestyle counselling. We used strategic sampling to obtain information
10 from doctors with as varied background and experience as possible. Six groups accepted the
11 invitation, one group did not answer. Two groups of interns (17 participants), one group of
12 residents (eight participants) and two groups of partners (13 participants) attended. One group
13 consisted of three residents and nine partners. Partners were specialists in general practice.
14 Groups of interns and residents have a supervisor. The supervisor did not participate in the
15 focus group sessions. The participants included 20 female and 30 male doctors. Twenty-nine
16 had graduated from Norwegian medical schools, 21 had graduated from medical schools in
17 seven different European countries. Among the specialists, 16 had worked more than ten
18 years as a specialist in family medicine. Eighteen physicians practiced in rural communities
19 with less than 10 000 inhabitants. Twenty-one worked in communities with between 10 000
20 and 20 000 inhabitants, while 11 worked in towns with more than 20 000 inhabitants. One
21 participant practiced solo, the rest worked in group practices.
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27 Having conducted six groups with 50 physicians, we experienced data saturation regarding
28 the topic on lifestyle counselling. We realised that we also had abundant examples of group
29 interactions.
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32 To initiate a dialogue in the focus groups we used the Critical Incident Technique.²¹
33 According to this procedure, we invited the participants to present case stories from their own
34 practice about lifestyle counselling which ended up as either a success or a failure. The group
35 members commented on each story, and told about similar or contrasting experiences. We
36 used no interview guide. The first author audio-taped and conducted the group sessions and
37 made field notes at the end of each session to supply transcripts. An observer, a sports
38 scientist, also made field notes, summarized his impressions, and asked for comments at the
39 end of each session to avoid misunderstandings. We considered audiotape recordings as an
40 acceptable basis to study verbal interaction.
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45 The first author, an experienced general practitioner, transcribed the audio-tapes verbatim. We
46 used Systematic Text Condensation and an editing analysis style in analysis.^{22 23} Bracketing
47 preconceptions, we first read the material searching for an overall impression. The first and
48 third author independently examined the text for units of meaning representing interaction and
49 process in the presentation and discussion of case stories. We coded and grouped these units,
50 contrasted and abstracted the content in each group, and finally discussed and summarised the
51 content of each group into generalised descriptions of aspects of interaction. If illustrating
52 quotes included more than one participant, we used fictive names to identify the participants.
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58 **Results**

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4 We analysed interactions among the participants when they presented and discussed case
5 stories about lifestyle counselling.
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9 *A different storyline*
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11 Some of the participants referred condensed case histories, including results of measurements,
12 laboratory tests and supplementary investigations. They described treatment outcomes in a
13 similar brief and objective way. The other group members seldom interrupted these
14 presentations, but asked questions and made comments after the case presentation. Other
15 stories were more detailed and expansive. In these sequences the storytellers presented their
16 own attitudes, emotions and reflections as well as their patients'. The other group members
17 often made comments and asked questions during these detailed case presentations, and in
18 this way co-authored the narrative. These stories often involved other aspects of the patients'
19 histories than the particular medical problem in question. Tom, an experienced partner, told
20 about his strategy when talking to patients who relapsed after smoking cessation:
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26 Tom: I try to motivate those who have quit smoking, and remind them that it is great
27 that they have managed to quit. Don't forget it.

28 Ben: Many times, and for those who have had a relapse, remind them that they have
29 succeeded once.
30

31 Sandra: Yes, that's right. Focus on what you [the patient] did to succeed.

32 Tom: Focus on what went wrong, what happened, and how we can prevent it from
33 happening again.
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37 *Discussing and solving disagreements*
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39 The case stories elicited discussions about how to handle clinical problems, the feasibility of
40 clinical guidelines, checklists and evidence based medicine. The participants carefully
41 suggested different counselling approaches, their own experience in similar situations and
42 commented politely on the proposals suggested. When disagreements occurred, we observed
43 moderate competition about being right, but the groups often reached mutual agreement. A
44 few times disagreement was solved by referring to clinical guidelines. The participants often
45 asked the rest of the group for advice, reflected upon ethical implications and discussed
46 cooperation with other healthcare providers. John, a male resident told a narrative about
47 treating a patient with obesity:
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52 Kate: You measured weight now and then?

53 John: Yes, in the beginning we did. We observed a nice reduction. It was the start of
54 a successful story which is unusual.
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56 Conductor: What do you think about measuring weight in such consultations?

57 Kate: I actually ask the patients about that, whether they want to be weighed or not. I
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3 think weighing is ambiguous, get stuck to numbers. Weight does not always
4 tell you about how the body changes.

5 John: Use waist circumference.
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9 *Case-based thinking*

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11 The case presentations initiated detailed discussions about the patients' agendas. The
12 participants discussed what they believed to be the particular patient's expectations about the
13 consultation, and the doctor's involvement. Some compared their patients' situation with their
14 own. The storyteller explained the sources of the patients' motivation for change of lifestyle,
15 and gave background information about the patients' experiences and identity beyond the
16 medical problem in question. The groups discussed how this information could be utilised in
17 the consultation.
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22 I had a patient that actually succeeded in losing weight. She was about 35 years old.
23 What made her succeed was that abdominal plastic surgery to remove excessive skin
24 folds should be paid for when her body mass index was normalised. That was her
25 motivation, to be operated and being able to wear bikini again. (Female resident)
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29 Detailed information about the patients initiated reflections among group members about the
30 complexity of many patients' lives, their self-efficacy and motivation for lifestyle change
31 despite these constraints. Several expressed respect and admiration of how their patients
32 managed.
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35 It is actually fascinating how much power that might be hidden behind rather poor
36 facades. A complicated family situation, severe obesity, unemployment. Actually
37 problems from A to Z. (female partner)
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40 Some participants defended their patients if other group members criticised or made jokes
41 about their patients during case discussions. Paula, a female intern presented a case story of a
42 man taking anabolic steroids:
43

44 Ann: What kind of education or work did he have?

45 Paula: I don't remember.

46 Ann: Security guard, maybe?

47 Mike: You are rather stereotype!

48 Ann: No, do you think he had any education?

49 Paula: No, I don't think so, but he was employed in sales business. He seemed quite
50 bright when I talked to him.
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55 In other situations, the doctors supported each other's denigration of patients, and made jokes
56 about them. Some case stories included patients who did not comply with the doctors'
57 proposals, even when non-compliance would imply a serious threat to the patient's health.
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3 The participants commented on how patients fooled themselves, made unwise decisions or
4 proposed easy solutions to solve complex problems. A group of partners discussed patients'
5 self reported dietary habits:
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8 Kate: The problem was that she ate next to nothing. She did everything right.

9 Peter: It's amazing. All of my obese patients belong to the group that tell they never
10 eat much.

11 Rose: They know they are lying.

12 Peter: Just let them write down what they eat for three days. Make an agreement
13 about three normal days.
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17 18 *Reflections about the professional role* 19

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21 The case stories initiated discussions of meta-perspectives. The participants commented on
22 the storyteller's professional behaviour, and how this behaviour affected the consultations and
23 the patients. The participants shared professional knowledge concerning medical ethics and
24 the need to tailor counselling to each patient. Stories about consultations that failed elicited
25 discussions about how to elicit the patient's agenda, the fear of provoking distrust, and the
26 problem of unintended intimidation of patients when approaching the patients' deeply rooted
27 habits.
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31 Maybe you do everything right. Then you end up by not giving him the responsibility,
32 in a way. In such a situation I would use the fatalistic part of me, and tell him that he
33 was responsible. Sometimes maybe we are too eager, and take the responsibility from
34 the patient. (Male partner)
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38 39 *Peer support* 40

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42 Several participants told about counselling that failed. This comprised complex situations
43 when both the doctor and the patient despaired, but also consultations in which the doctor
44 made proposals or decisions they later regretted. Some expressed significant emotional
45 involvement and personal disappointment when communication failed, others told about their
46 own struggle with lifestyle. The participants shared frustration related to insufficient support
47 from specialized health care, reluctant patients, and difficulties in doctor-patient
48 communication. Discussing these narratives, peer group members offered care and support,
49 but also constructive critique and alternative solutions. They often responded by telling about
50 similar experiences, and argued that doctors should expect limited success in complex
51 consultations:
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55 Rose: I thought about it after she had been there, that fifteen or twenty minutes - she
56 should have fifteen or twenty minutes to solve each of those problems.

57 Jane: It can be too much for a family physician, when specialist health care tells you
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3 to follow up every patient.

4 Edith: But we should not solve everything. I have low ambitions about solving other
5 people's health problems.
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10 *Informal associations*

11 The informal atmosphere in the peer-groups allowed spontaneous associations and proposals,
12 including suggestions about how to organise health care and ideas about alternative ways of
13 counselling patients. The participants joked and told anecdotes, triggered by the case
14 discussions and associations from their own life. A group of residents discussed repetitively
15 reminding patients to quit smoking:
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19 Eric: Just mention smoking when they come in. I think it enhances motivation in the
20 long run. My dentist has asked me every year if I use fluoride, and I don't. But
21 the last two months I have used it, because he asked again. He has not done
22 anything but ask me every time I met him.
23

24 Ruth: Same with me, but I have not managed yet.

25 Peter: Isn't it better to use dental floss?

26 Eric: But who uses dental floss?

27 Ruth: I'm thinking about it (laughter).
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32 **Discussion**

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34 The storyline of case presentations in focus groups included detailed stories with emotional
35 engagement and co-authoring from other group members. The group interaction initiated
36 discussions about the patients' and doctors' behaviours and agendas in the consultations,
37 ethical implications and the handling of clinical problems in everyday practice. The case
38 stories inspired group members to reflect upon the complexity of counselling and the doctors'
39 roles. The participants offered each other critique and peer support.
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44 The presence of the researchers in the focus groups may have influenced what group members
45 chose to tell.²⁴ To reduce this influence, the conductor chose a withdrawn position, and
46 seldom interrupted the group discussions. Being a peer may elicit information that would not
47 be told to a researcher with a different background,²⁵ but may also cause blindness to aspects
48 of the discussions that a researcher with different background would see. This was
49 compensated to some extent by the presence of an observer with another professional
50 background. The group members knew each other quite well, and we conducted the group
51 sessions in a scheduled meeting. The participants discussed real case stories from their own
52 practice. This strengthens the validity of the study. Video recordings would have provided
53 more information about non-verbal communication, but also increased the possibility of
54 information overload.
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3 Some of the case stories followed the traditional, succinct storyline of case presentation, while
4 expansive stories represented a different genre, encompassing more focus on the patients' life
5 context. We observed co-authoring during the expansive case presentations. In focus groups
6 the audience may supply the speaker by verbal interruption, exclamations, supportive or
7 confronting utterances, and by non-verbal communication. The speaker may address the
8 whole group, or a selected person. Moments of 'split floor' and polyphonic discussions occur,
9 as well as moments in which nobody wants to 'take the floor'.²⁶ In this study we observed
10 'split floor' and polyphonic discussions, but never moments when nobody 'took the floor'.
11 This may be because the participants knew each other well, and the topic was engaging.
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15 Prepared, condensed presentations represents front stage communication,²⁷ also described in
16 studies of morning reports in hospitals.^{2,28} In front stage communication the 'actor' plays the
17 expected role. Front stage communication can be presented to anyone. Detailed case stories
18 with emotional engagement that admit uncertainty or failure, represent back stage
19 communication.²⁷ This is not meant for outsiders, and only occurs in a safe environment.
20 Professional back stage communication is included in the hidden curriculum of medical
21 education, supports each group member and strengthens group affiliation.^{29,30}
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25 Humans socialize into groups that share social knowledge and communication.^{31,32} Peer
26 groups of general practitioners share professional competence, experience and social roles.
27 Socially shared knowledge is formed and maintained through dialogical communication, and
28 shapes what is being spoken about and the manner by which contents are framed.⁸ We
29 observed that this influenced how group members spoke about patients, other professionals
30 and governmental institutions.
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33 We noticed spontaneous associations, jokes about patients and anecdotes about controversial
34 behaviour of doctors, reflecting an informal, supportive back stage atmosphere and group
35 affiliation. We also observed attempts to try out controversial statements. Testing out the
36 limits of acceptable behaviour is a frequent strategy in dialogues. While people talk to each
37 other, they simultaneously carry out internal dialogues with themselves or others to position
38 themselves in the discussion.⁸ A participant may not wish to reveal her true opinion, be
39 humiliated or step out of the group. This can be solved by using incomplete utterances, jokes,
40 quoting 'third parties' and prompting for collaborative utterances.³³ Disrespectful comments
41 about patients in some instances initiated constructive critique and a reminder of the ethical
42 behaviour. The discussions addressed moral perception and the ability to identify ethical
43 aspects in clinical situations.³⁴
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49 Some participants told about their own struggle with lifestyle. Several narratives concerned
50 counselling that failed. The group members obviously trusted each other, and utilized the peer
51 group as an arena of debriefing and peer support. Brondt et al showed that participation in
52 peer groups as part of CME was associated with decreased risk of professional dysfunction
53 among Danish GPs.³⁵
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56 The participants discussed patients' behaviour on a distanced level, but also demonstrated
57 close, personal emotional involvement in patients' life world, and intentions of exploring
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3 patients' agenda. We have used the concept 'case-based thinking' to signify how a case-based
4 narrative approach expands the emphasis on medical knowledge and the medical problem in
5 question, to encompass context, personal and emotional involvement where only thin layers
6 of distance exist between the general practitioner and the patient. A distinction exists between
7 patient-centred care and person-focused care. The latter has a much broader, encompassing
8 focus. Person-focused care is based on accumulated knowledge of people, which provides the
9 basis for better recognition of health problems and needs over time, and facilitates appropriate
10 care for these needs in the context of other needs.^{36 37}

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14 The group interaction initiated discussions about best practice, and exchange of practical tips.
15 The starting point of the discussions was not theory or evidence, but clinical experience.
16 However, in some situations the participants referred to clinical guidelines to solve
17 disagreements. Peer group meetings are suitable for introduction of attempts to improve
18 practice skills.^{38 39} The storyteller tradition of case stories put clinical problems into context,
19 and seemed to promote mutual reflections about counselling that might enhance meaning-
20 making and reflective practice.⁴⁰

21 22 23 24 **Conclusion**

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27 Presentations and discussions of case stories in peer groups of general practitioners followed a
28 detailed storyline, and initiated dialogues that highlighted patients' perspectives and
29 facilitated learning, discussions of best practice and reflections on medical ethics. The safe
30 backstage atmosphere permitted expression of emotions, peer support, and testing out ideas
31 and opinions. The interaction facilitated sense-making and meaning-making activity that
32 influenced socially shared knowledge within the group.

33 34 35 36 37 **Acknowledgements**

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39 assisted as observer in the focus group discussions.

40 41 42 **Competing interests** None

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44
45 **Contributors** EA and PS prepared the study protocol. EA collected the data. All authors were
46 involved in analysis, interpretation and drafting the manuscript. EA is the guarantor.

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49 **Ethical approval** The study did not involve patients. The doctors presented all case stories
50 anonymously. The Regional Committee for Ethics in Medical Research regarded the study not
51 to be within their mandate. All participants signed a declaration of informed consent before
52 participation.

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54
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Case stories in general practice: A focus group study

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3 **Case stories in general practice: A focus group study.**
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57 **Case stories in general practice: A focus group study .**
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Abstract

Objectives To explore the interactive process of sharing case stories in small-group activity in general practice.

Design Qualitative focus group study.

Setting Peer group meetings of doctors attending specialist training or continuous medical education in general practice.

Participants Twenty female and 30 male doctors working in general practice in Norway.

Results The storyline of case presentations included detailed stories with emotional engagement, co-authored by other group members. The stories initiated discussions and reflections concerning patients' and doctors' perspectives, medical ethics as well as clinical problems. The safe atmosphere allowed testing out boundaries of socially shared knowledge.

Conclusions Sharing case stories in small-groups in general practice initiated interaction that facilitated meaning-making, reflection and peer support.

Article summary

Article focus

- Sharing case stories have longstanding traditions among doctors. General practitioners share case stories in small-group learning.
- Socially shared knowledge is formed and maintained through dialogical thinking and communication, and affects what is being talked about and the manner by which content is framed.
- We intended to explore the interactive process of discussing case stories in peer groups of general practitioners.

Key messages

- Case presentations in focus groups included detailed stories with emotional engagement and co-authoring from other group members.

The case stories initiated discussions facilitating attention to person-focused care. Case story discussions in small-group learning functioned as an arena for testing out communication strategies to be used in consultations.

Strengths and limitations

- The presence of the researchers influenced what group members chose to tell.
- Being a peer may cause blindness to aspects of the discussions that a researcher with different background would see.
- The participants discussed real case stories from their own practice.

Introduction

Case stories have a longstanding tradition in medicine. Doctors share case stories when referring patients to hospital from primary health care, at morning reports in hospital, and when discussing interesting or difficult cases.^{1,2} Case stories include everyday practice, dramatic “war stories” and anecdotes of uncommon practice. The stories aim to provide a professional audience with succinct and sufficient information to understand the specific clinical problem.³ Doctors adopt the storyline of case presentations early in their career. During case presentations students, interns and residents improve knowledge based on clinical experience, and learn the medical language, professional principles, traditions and values.⁴ Their supervisors evaluate their presentations based on relevance, conciseness and mastery of the medical language.⁵ Doctors adjust their retelling and interpretations of the patients’ stories into case stories suitable for a professional audience.⁶

Peer groups of general practitioners share professional competence, experience and social role. Such socially shared knowledge has an interactive nature. It is formed and maintained through dialogical communication, and determines what is being talked about and the manner by which content is framed.⁷ It influences how group members speak about others, such as patients, other professionals or health authorities. Dialogues involve tension and intentions, and dealing with this implicit shared knowledge within a group is an important social skill.⁸ The distribution of this competence within a group may affect group dynamics, and the outcome of group discussions. Communication is affected by fear of losing face, indirect communication and hidden agendas. Group members may carry out unspoken, internal dialogues to try out their communication strategies before they take part in the spoken discussion.⁷

Research on the development of doctors’ communication patterns emphasizes that medical education, internship and residency influence doctors’ identities in ways that affect communication with patients.⁹ Case-based teaching is used along with problem-based teaching in medical education, and is well suited for small-group teaching.¹⁰ Problem-based teaching focuses on a particular clinical problem, while case-based teaching focuses on a particular patient presenting with a clinical problem. In general practice case-based learning in organized peer groups is widely used.¹¹⁻¹⁴ Permanent small-group activities have become an important part of CME in many countries, and can serve as supportive networks to share knowledge and clinical experience.¹⁵⁻¹⁸

While conducting focus group sessions among general practitioners to study general practitioners’ experience with lifestyle counselling,¹⁹ we observed interesting interaction within the groups. We have not identified studies that explore the interactive process of discussing case stories. The aim of this paper is to explore and describe how peer groups of general practitioners interact when they share and discuss case stories.

Methods

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4 In Norway interns spend six months of their internship in general practice, and they attend to
5 supervised peer groups in these months. In specialist training in general practice, residents
6 (specialist candidates) attend to three years of participation in supervised peer groups while
7 they work in general practice. All partners (specialists in general practice, practicing
8 physicians) attend to peer groups as a mandatory part of continuous medical education. In
9 Norway it is required to recertify as specialist in general practice every fifth year. All
10 groups meet four to six times a year, each meeting lasts two to three hours.
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14 We invited seven established peer groups from the southern part of Norway to attend focus
15 group sessions on lifestyle counselling. We used strategic sampling to obtain information
16 from doctors with as varied background and experience as possible. Six groups accepted the
17 invitation, one group did not answer. Two groups of interns (17 participants), one group of
18 residents (eight participants) and two groups of partners (13 participants) attended. The last
19 group consisted of three residents and nine partners. The supervisor of interns and residents
20 did not participate in the focus group sessions. The participants included 20 female and 30
21 male doctors. Twenty-nine had graduated from Norwegian medical schools, 21 had graduated
22 from medical schools in seven other European countries. Among the partners, 16 had worked
23 more than ten years as a specialist in general practice. Eighteen physicians practiced in rural
24 communities with less than 10 000 inhabitants. These participants did not differ from the rest
25 with respect to background and clinical experience. Twenty-one worked in communities with
26 between 10 000 and 20 000 inhabitants, while 11 worked in towns with more than 20 000
27 inhabitants. One participant practiced alone, the rest worked in group practices.
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33 Having conducted six groups with 50 physicians, we experienced data saturation regarding
34 the topic on lifestyle counselling. We realised that we also had abundant examples of group
35 interactions regarding the case story discussions.
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38 To initiate a dialogue in the focus groups we used the Critical Incident Technique.²⁰
39 According to this procedure, we invited the participants to present case stories from their own
40 practice about lifestyle counselling which ended up as either a success or a failure. The group
41 members commented on each story, and told about similar or contrasting experiences. We
42 used no interview guide. The first author audio-taped and conducted the group sessions and
43 made field notes at the end of each session to supply transcripts. An observer, a sports
44 scientist, also made field notes, summarized his impressions, and asked for comments at the
45 end of each session to avoid misunderstandings. We considered audiotape recordings to
46 provide sufficient information to study verbal interaction.
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51 The first author, an experienced general practitioner, transcribed the audio-tapes verbatim. We
52 used Systematic Text Condensation and an editing analysis style in analysis.^{21 22} Bracketing
53 preconceptions, we first read the material searching for an overall impression. The first and
54 third author independently examined the text for units of meaning representing interaction and
55 process in the presentation and discussion of case stories. We coded and grouped these units,
56 contrasted and abstracted the content in each group, and finally discussed and summarised the
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3 content of each group into generalised descriptions of aspects of interaction. If illustrating
4 quotes included more than one participant, we used fictitious names to identify the
5 participants.
6

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8 We analysed interactions among the participants when they presented and discussed case
9 stories about lifestyle counselling.
10

11 **Results**

12 *A different storyline of case presentations*

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16
17 Some of the participants presented condensed case histories, focusing on objective data
18 including results of measurements, laboratory tests and supplementary investigations. They
19 described treatment outcomes in a similar brief and objective way. The other group members
20 seldom interrupted these presentations, but asked questions and made comments after the case
21 presentation. Other stories were more detailed and expansive. In these sequences the
22 storytellers presented their own attitudes, emotions and reflections as well as their patients'.
23 The other group members often made comments and asked questions during these detailed
24 case presentations, and in this way co-authored the story. These stories often involved other
25 aspects of the patients' histories than the particular medical problem in question. Tom, an
26 experienced partner, told about his strategy when talking to patients who relapsed after
27 smoking cessation.
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32 Tom: I try to motivate those who have quit smoking, and remind them that it is great
33 that they have managed to quit. Don't forget it.

34 Ben: Many times, and for those who have had a relapse, remind them that they have
35 succeeded once.

36 Sandra: Yes, that's right. Focus on what you [the patient] did to succeed.

37 Tom: Focus on what went wrong, what happened, and how we can prevent it from
38 happening again.
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43 *Discussing and solving disagreements*

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46 The case stories elicited discussions about how to handle clinical problems, the feasibility of
47 clinical guidelines, checklists and evidence based medicine. The participants carefully
48 suggested different counselling approaches, their own experience in similar situations and
49 commented politely on the proposals suggested. When disagreements occurred, we observed
50 moderate competition about being right, but the groups often reached mutual agreement. A
51 few times disagreement was solved by referring to clinical guidelines. The participants often
52 asked the rest of the group for advice, reflected upon ethical implications and discussed
53 cooperation with other healthcare providers. John, a male resident told a story about treating a
54 patient with obesity.
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3 Kate: You measured weight now and then?

4 John: Yes, in the beginning we did. We observed a nice reduction. It was the start of
5 a successful story which is unusual.

6
7 Conductor: What do you think about measuring weight in such consultations?

8 Kate: I actually ask the patients about that, whether they want to be weighed or not. I
9 think weighing is ambiguous, get stuck to numbers. Weight does not always
10 tell you about how the body changes.

11 John: Use waist circumference.
12
13

14 15 16 *Case-based thinking*

17
18 The case presentations initiated detailed discussions about the patients' agendas. The
19 participants discussed what they believed to be the particular patient's expectations about the
20 consultation, and the doctor's involvement. Some compared their patients' situation with their
21 own. The storyteller explained the sources of the patients' motivation for change of lifestyle,
22 and gave background information about the patients' experiences and identity beyond the
23 medical problem in question. The groups discussed how this information could be utilised in
24 the consultation.
25
26

27
28 I had a patient who actually succeeded in losing weight. She was about 35 years old.
29 What made her succeed was that abdominal plastic surgery to remove excessive skin
30 folds should be paid for when her body mass index was normalised. That was her
31 motivation, to be operated and being able to wear bikini again. (Female resident)
32
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35 Detailed information about the patients initiated reflections among group members about the
36 complexity of many patients' lives, their self-efficacy and motivation for lifestyle change
37 despite these constraints. Several expressed respect and admiration of how their patients
38 managed their lives.
39

40 It is actually fascinating how much power that might be hidden behind rather poor
41 facades. A complicated family situation, severe obesity, unemployment. Actually
42 problems from A to Z. (female partner)
43
44

45 Some participants defended their patients if other group members criticised or made jokes
46 about them during case discussions. Paula, a female intern presented a case story of a man
47 taking anabolic steroids:
48

49
50 Ann: What kind of education or work did he have?

51 Paula: I don't remember.

52 Ann: Security guard, maybe?

53 Mike: You are rather stereotype!

54 Ann: No, do you think he had any education?

55 Paula: No, I don't think so, but he was employed in sales business. He seemed quite
56 bright when I talked to him.
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4 In other situations, the doctors supported each other's denigration of patients. Some case
5 stories included patients who did not comply with the doctors' proposals, even when non-
6 compliance would imply a serious threat to the patient's health. The participants commented
7 on how patients fooled themselves, made unwise decisions or proposed too easy solutions to
8 solve complex problems. A group of partners discussed patients' self reported dietary habits:
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11 Kate: The problem was that she ate next to nothing. She did everything right.

12 Peter: It's amazing. All of my obese patients belong to the group that tell they never
13 eat much.

14 Rose: They know they are lying.

15 Peter: Just let them write down what they eat for three days. Make an agreement
16 about three normal days.
17
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20 21 *Reflections about the professional role*

22
23 The case stories initiated discussions of meta-perspectives. The participants commented on
24 the storyteller's professional behaviour, and how this behaviour affected the consultations and
25 the patients. The participants shared professional knowledge concerning medical ethics and
26 the need to tailor counselling to each patient. Stories about consultations that failed led to
27 discussions about how to elicit the patient's agenda, the fear of provoking distrust, and the
28 problem of unintended intimidation of patients when approaching the patients' deeply rooted
29 habits.
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33 Maybe you do everything right. Then you end up by not giving him the responsibility,
34 in a way. In such a situation I would use the fatalistic part of me, and tell him that he
35 was responsible. Sometimes maybe we are too eager, and take the responsibility from
36 the patient. (Male partner)
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40 41 *Peer support*

42
43 Several participants told about counselling that failed. This comprised complex situations
44 when both the doctor and the patient despaired, but also consultations in which the doctors
45 made proposals or decisions they later regretted. Some expressed significant emotional
46 involvement and personal disappointment when communication failed, others told about their
47 own struggle with lifestyle. The participants shared frustration related to insufficient support
48 from specialized health care, reluctant patients, and difficulties in doctor-patient
49 communication. Discussing these narratives, peer group members offered care and support,
50 but they also gave constructive critique and suggested alternative solutions. They often
51 responded by telling about similar experiences, and argued that doctors should expect limited
52 success in consultations with patients with complex problems:
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56 Rose: I thought about it after she had been there, that fifteen or twenty minutes - she
57 should have fifteen or twenty minutes to solve each of those problems.
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3 Jane: It can be too much for a family physician, when specialist health care tells you
4 to follow up every patient.
5 Edith: But we should not solve everything. I have low ambitions about solving other
6 people's health problems.
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10 *Informal associations*

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13 The informal atmosphere in the peer-groups allowed spontaneous associations and proposals,
14 including suggestions about how to organise health care and ideas about alternative ways of
15 counselling patients. The participants joked and told anecdotes, triggered by the case
16 discussions and personal experiences from their own private and professional life. A group of
17 residents discussed repetitively reminding patients to quit smoking:
18
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- 20
21 Eric: Just mention smoking when they come in. I think it enhances motivation in the
22 long run. My dentist has asked me every year if I use fluoride, and I don't. But
23 the last two months I have used it, because he asked again. He has not done
24 anything but ask me every time I met him.
25
26 Ruth: Same with me, but I have not managed yet.
27 Peter: Isn't it better to use dental floss?
28 Eric: But who uses dental floss?
29 Ruth: I'm thinking about it (laughter).
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33 **Discussion**

34 *Short summary of the main findings*

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38 The storyline of case presentations in focus groups included detailed stories with emotional
39 engagement and co-authoring from other group members. The group interaction initiated
40 discussions about the patients' and doctors' behaviours and agendas in the consultations,
41 ethical implications and the handling of clinical problems in everyday practice. The case
42 stories inspired group members to reflect upon the complexity of counselling and the doctors'
43 roles. The participants offered each other constructive critique and peer support.
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47 *Strengths and weaknesses*

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50 The presence of the researchers in the focus groups may have influenced what group members
51 chose to tell.²³ To reduce this influence, the conductor chose a withdrawn position, and
52 seldom interrupted the group discussions. Being a peer may elicit information that would not
53 be told to a researcher with a different background,²⁴ but may also cause blindness to aspects
54 of the discussions that a researcher with different background would see. This was
55 compensated to some extent by the presence of an observer with another professional
56 background. The group members knew each other quite well, and we conducted the group
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3 sessions in a scheduled meeting. The participants discussed real case stories from their own
4 practice. This strengthens the validity of the study. Video recordings would have provided
5 more information about non-verbal communication, but also increased the possibility of
6 information overload.
7

8 9 *Dialogical interaction*

10
11 Some of the case stories followed the traditional, succinct storyline of case presentation, while
12 expansive stories represented a different genre, with more focus on the patients' life context.
13 We observed co-authoring during the expansive case presentations. In focus groups the
14 audience may interact with the speaker by verbal interruption, exclamations, supportive or
15 confronting utterances, and by non-verbal communication. The speaker may address the
16 whole group, or a selected person. Moments of 'split floor' discussions occur when different
17 subgroups speak together. Polyphonic discussions occur when several participants take part in
18 the same discussion. There may be moments of silence when nobody wants or dares to 'take
19 the floor'.²⁵ In this study we observed 'split floor' and polyphonic discussions, but no long
20 periods of silence. This may be because the participants knew each other well, and the topic
21 was engaging.
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26 27 *Frames of interaction*

28
29 Prepared, condensed presentations represents front stage communication,²⁶ also described in
30 studies of morning reports in hospitals.^{2,27} In front stage communication the 'actor' plays the
31 expected role. Front stage communication can be presented to anyone. Detailed case stories
32 with emotional engagement that admit uncertainty or failure, represent back stage
33 communication.²⁶ This is not meant for outsiders, and occurs only in a safe environment.
34 Professional back stage communication is included in the hidden curriculum of medical
35 education.^{28,29} Humans socialize into groups that share social knowledge and communication.
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Peer groups of general practitioners share professional competence, experience and social
roles. Socially shared knowledge is formed and maintained through dialogical
communication, and shapes what is being spoken about and the manner by which contents are
framed.⁷ We observed that this influenced how group members spoke about patients, other
professionals and governmental institutions.

59 60 *An arena for testing out communications strategies*

We noticed spontaneous associations, jokes about patients and anecdotes about controversial
behaviours of doctors, reflecting an informal, supportive back stage atmosphere and group
affiliation. We also observed attempts to try out controversial statements. Testing out the
limits of acceptable behaviour is a frequent strategy in dialogues. While people talk to each
other, they simultaneously carry out internal dialogues to prepare for positioning themselves
in the discussion.⁷ A participant may not wish to reveal her true opinion, be humiliated or
step out of the group. This can be solved by using incomplete utterances, jokes, quoting 'third
parties' and prompting for collaborative utterances.³² Disrespectful comments about patients
in some instances initiated constructive critique and a reminder of the ethical behaviour. The

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3 discussions addressed moral perception and the ability to identify ethical aspects in clinical
4 situations.³³ Some participants talked about their own struggle with lifestyle. Several
5 narratives concerned counselling that failed. The group members trusted each other, and
6 utilized the peer group as an arena of debriefing and peer support. Brondt et al found that
7 participation in peer groups as part of CME was associated with decreased risk of professional
8 dysfunction among Danish GPs.³⁴

11 *Facilitating person-focused care*

14 The atmosphere in the focus groups was supportive. The participants presented and discussed
15 case stories in a cautious tone. By presenting their stories, they also presented themselves,
16 thereby putting their own engagement at stake. The participants discussed patients' behaviour
17 on a distanced level, but also demonstrated close, personal emotional involvement in patients'
18 life world, and intentions of exploring patients' agenda. A distinction exists between patient-
19 centred care and person-focused care. Person-focused care is based on accumulated
20 knowledge of individuals, which provides the basis for better recognition of health problems
21 over time, and facilitates appropriate care.^{35,36} We have used the concept 'case-based
22 thinking' to signify how a case-based approach expands the emphasis on medical knowledge
23 and the clinical problem in question, to encompass the context and the personal and
24 emotional involvement where only thin layers of distance exist between the general
25 practitioner and the patient. Dialogues among GPs based on 'case-based thinking' may have
26 consequences for how GP relate to the clinical problem in question, and to how disagreements
27 are solved. We only observed moderate competition about being right, and the group
28 members often asked each other for advice. They often reached mutual agreement, and
29 discussed ethical implications of their actions.

36 *Implications for practice and research*

38 The case stories led to discussions about best practice and exchange of useful tips. The
39 starting point of the discussions was not theory or research evidence, but clinical experience.
40 However, in some situations the participants referred to clinical guidelines to solve
41 disagreements. Peer group meetings are suitable for introduction of attempts to improve
42 practice skills.^{37,38} The storyteller tradition of case stories put clinical problems into context,
43 and seemed to promote mutual reflections about counselling that might enhance meaning-
44 making and reflective practice.³⁹ We still need more information about how doctors think and
45 learn, and how they develop and change clinical skills. Such information is available from
46 peer groups of doctors.

51 **Conclusion**

54 Presentations and discussions of case stories in peer groups of general practitioners followed a
55 detailed storyline, and initiated dialogues that highlighted patients' perspectives and
56 facilitated learning, discussions of best practice and reflections on medical ethics. The safe
57 backstage atmosphere permitted the general practitioners to express emotions and peer
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3 support, and to test out ideas and opinions. The interactions facilitated sense-making and
4 meaning-making and influenced socially shared knowledge within the group.
5
6

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9 assisted as observer in the focus group discussions.
10

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12
13
14 **Contributors** EA and PS prepared the study protocol. EA collected the data. All authors were
15 involved in analysis, interpretation and drafting the manuscript. EA is the guarantor.
16

17
18 **Ethical approval** The study did not involve patients. The doctors presented all case stories
19 anonymously. The Regional Committee for Ethics in Medical Research regarded the study not
20 to be within their mandate. All participants signed a declaration of informed consent before
21 participation.
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Case stories in small-group activity in general practice: A focus group study, from
backstage

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7 **Case stories in small-group activity in general practice: A focus group study from**
8 **backstage.**
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10 Abstract

11 **Objectives** To explore the interactive process of sharing case stories in small-group activity in
12 general practice.

13 **Design** Qualitative focus group study.

14 **Setting** Peer group meetings of doctors attending specialist training or continuous medical
15 education in general practice.

16 **Participants** Twenty female and 30 male doctors working in general practice in Norway.

17 **Results** The storyline of case presentations included detailed stories with emotional
18 engagement, co-authored by other group members. The stories initiated discussions and
19 reflections concerning patients' and doctors' perspectives, medical ethics as well as clinical
20 problems. The safe atmosphere allowed testing out boundaries of socially shared knowledge.

21 **Conclusions** Sharing case stories in small-groups in general practice initiated interaction that
22 facilitated meaning-making, reflection and peer support.
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27 Article summary

28 Article focus

- 29 • Sharing case stories have longstanding traditions among doctors. General practitioners
30 share case stories in small-group learning.
- 31 • Socially shared knowledge is formed and maintained through dialogical thinking and
32 communication, and affects what is being talked about and the manner by which
33 content is framed.
- 34 • We intended to explore the interactive process of discussing case stories in peer
35 groups of general practitioners.
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40 Key messages

- 41 • Case presentations in focus groups included detailed stories with emotional
42 engagement and co-authoring from other group members.
- 43 • ~~The case stories initiated~~ Group interaction initiated discussions facilitating attention
44 to person-focused care. about the patients' and doctors' behaviours and agendas,
45 ethical implications and the handling of clinical problems in everyday practice.
- 46 • ~~Case story discussions in small-group learning functioned as an arena for testing out~~
47 communication strategies to be used in consultations. inspired group members to
48 reflect upon the complexity of counselling and the doctors' roles. The participants
49 offered each other critique and peer support.
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52 Strengths and limitations

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- The presence of the researchers influenced what group members chose to tell.
- Being a peer may cause blindness to aspects of the discussions that a researcher with different background would see.
- The participants discussed real case stories from their own practice.

Introduction

Case stories have a longstanding traditions in medicine. Doctors share case stories when referring patients to hospital from primary health care, at morning reports in hospital, and when discussing interesting or difficult cases.^{1,2} Case stories include everyday practice, dramatic “war stories” and anecdotes of uncommon practice. The stories aim to provide a professional audience with succinct and sufficient information to understand the specific clinical problem.³ Doctors adopt the medical storyline of case presentations early in their career. During case presentations students, interns and residents improve knowledge based on clinical experience, and learn the medical language, professional principles, traditions and values.⁴ Their supervisors evaluate their presentations based on relevance, conciseness and mastery of the medical language.⁵ Patients adjust their illness narratives to the listening doctor,⁶ Doctors adjust their retelling and interpretations of the patients’ stories into case stories suitable for a professional audience.^{6,7}

Peer groups of general practitioners share professional competence, experience and social role. Such socially shared knowledge has an interactive nature. It is formed and maintained through dialogical thinking and communication, and determines affects what is being talked about and the manner by which content is framed.^{7,8} It influences how group members speak about others, such as patients, other professionals or health authorities. Dialogues involve tension and intentions, and dealing with this implicit shared knowledge within a group is an important social skill.^{8,9} The distribution of this competence within a group may affect group dynamics, and the outcome of group discussions. Communication is affected by fear of losing face, indirect communication and hidden agendas. Group While group members talk to each other, they may simultaneously carry out unspoken, internal dialogues with themselves or othersto try out their communication strategies before they take part in the spoken discussion.^{7,8}

Research on the development of doctors’ communication patterns emphasizes that medical education, internship and residency influence doctors’ identities in ways that affect communication with patients.^{9,10} Case-based teaching is used along with problem-based teaching in medical education, and is well suited for small-group teaching.^{10,11} Problem-based teaching focuses on a particular clinical problem, while case-based teaching focuses on a particular patient presenting with a clinical problem. In general practice case-based learning in organized peer groups is widely used.^{11-14,12-15} Permanent small-group activities have become an important part of CME in many countries, and if well functioning can serve as supportive networks to share knowledge and clinical experience.^{15-18,16-19}

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7 ~~The primary aim of the research project was to study general practitioners' experience with~~
8 ~~lifestyle counselling.~~ While conducting focus group sessions among general practitioners to
9 study general practitioners' experience with lifestyle counselling,^{19,20} we observed interesting
10 interaction within the groups, ~~and decided to explore this interaction in detail.~~ We have not
11 identified studies that explore the interactive process of discussing case stories. The aim of
12 this paper is to explore and describe how-in peer groups of general practitioners interact when
13 they share and discuss case stories, ~~and aimed to do so in this paper.~~

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Methods

In Norway interns spend six months of their internship in general practice, and they attend to
supervised peer groups in these months. In specialist training in general practice, residents
(specialist candidates) attend to three years of participation in supervised peer groups while
they work in general practice. All partners (specialists in general practice, practicing
physicians) attend to peer groups as a mandatory part of continuous medical education. In
Norway it is required to recertify as specialist in general practice every fifth year. All
groups meet four to six times a year, each meeting lasts two to three hours.

We invited seven established peer groups from the southern part of Norway to attend focus group sessions on lifestyle counselling. We used strategic sampling to obtain information from doctors with as varied background and experience as possible. Six groups accepted the invitation, one group did not answer. Two groups of interns (17 participants), one group of residents (eight participants) and two groups of partners (13 participants) attended. The last~~One~~ group consisted of three residents and nine partners. ~~Partners were specialists in general practice. Groups of interns and residents have a supervisor.~~ The supervisor of interns and residents did not participate in the focus group sessions. The participants included 20 female and 30 male doctors. Twenty-nine had graduated from Norwegian medical schools, 21 had graduated from medical schools in seven ~~other~~different European countries. Among the ~~partners~~specialists, 16 had worked more than ten years as a specialist in general practice~~family medicine~~. Eighteen physicians practiced in rural communities with less than 10 000 inhabitants. These participants did not differ from the rest with respect to background and clinical experience. Twenty-one worked in communities with between 10 000 and 20 000 inhabitants, while 11 worked in towns with more than 20 000 inhabitants. One participant practiced ~~alonesole~~, the rest worked in group practices.

Having conducted six groups with 50 physicians, we experienced data saturation regarding the topic on lifestyle counselling. We realised that we also had abundant examples of group interactions regarding the case story discussions.

To initiate a dialogue in the focus groups we used the Critical Incident Technique.²⁰²¹ According to this procedure, we invited the participants to present case stories from their own practice about lifestyle counselling which ended up as either a success or a failure. The group members commented on each story, and told about similar or contrasting experiences. We used no interview guide. The first author audio-taped and conducted the group sessions and

made field notes at the end of each session to supply transcripts. An observer, a sports scientist, also made field notes, summarized his impressions, and asked for comments at the end of each session to avoid misunderstandings. We considered audiotape recordings ~~to provide sufficient information as an acceptable basis~~ to study verbal interaction.

The first author, an experienced general practitioner, transcribed the audio-tapes verbatim. We used Systematic Text Condensation and an editing analysis style in analysis. ~~21 2222-23~~ Bracketing preconceptions, we first read the material searching for an overall impression. The first and third author independently examined the text for units of meaning representing interaction and process in the presentation and discussion of case stories. We coded and grouped these units, contrasted and abstracted the content in each group, and finally discussed and summarised the content of each group into generalised descriptions of aspects of interaction. If illustrating quotes included more than one participant, we used fictitious names to identify the participants.

~~We analysed interactions among the participants when they presented and discussed case stories about lifestyle counselling.~~

Results

~~We analysed interactions among the participants when they presented and discussed case stories about lifestyle counselling.~~

A different storyline of case presentations

Some of the participants ~~presented~~ referred condensed case histories, focusing on objective data including results of measurements, laboratory tests and supplementary investigations. They described treatment outcomes in a similar brief and objective way. The other group members seldom interrupted these presentations, but asked questions and made comments after the case presentation. Other stories were more detailed and expansive. In these sequences the storytellers presented their own attitudes, emotions and reflections as well as their patients'. The other group members often made comments and asked questions during these detailed case presentations, and in this way co-authored the story narrative. These stories often involved other aspects of the patients' histories than the particular medical problem in question. Tom, an experienced partner, told about his strategy when talking to patients who relapsed after smoking cessation:

Tom: I try to motivate those who have quit smoking, and remind them that it is great that they have managed to quit. Don't forget it.

Ben: Many times, and for those who have had a relapse, remind them that they have succeeded once.

Sandra: Yes, that's right. Focus on what you [the patient] did to succeed.

Tom: Focus on what went wrong, what happened, and how we can prevent it from

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11 *Discussing and solving disagreements*

12 The case stories elicited discussions about how to handle clinical problems, the feasibility of
13 clinical guidelines, checklists and evidence based medicine. The participants carefully
14 suggested different counselling approaches, their own experience in similar situations and
15 commented politely on the proposals suggested. When disagreements occurred, we observed
16 moderate competition about being right, but the groups often reached mutual agreement. A
17 few times disagreement was solved by referring to clinical guidelines. The participants often
18 asked the rest of the group for advice, reflected upon ethical implications and discussed
19 cooperation with other healthcare providers. John, a male resident told a ~~story~~narrative about
20 treating a patient with obesity:
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22 Kate: You measured weight now and then?

23 John: Yes, in the beginning we did. We observed a nice reduction. It was the start of
24 a successful story which is unusual.

25 Conductor: What do you think about measuring weight in such consultations?

26 Kate: I actually ask the patients about that, whether they want to be weighed or not. I
27 think weighing is ambiguous, get stuck to numbers. Weight does not always
28 tell you about how the body changes.

29 John: Use waist circumference.
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33 *Case-based thinking*

34 The case presentations initiated detailed discussions about the patients' agendas. The
35 participants discussed what they believed to be the particular patient's expectations about the
36 consultation, and the doctor's involvement. Some compared their patients' situation with their
37 own. The storyteller explained the sources of the patients' motivation for change of lifestyle,
38 and gave background information about the patients' experiences and identity beyond the
39 medical problem in question. The groups discussed how this information could be utilised in
40 the consultation.
41

42 I had a patient ~~who~~that actually succeeded in losing weight. She was about 35 years
43 old. What made her succeed was that abdominal plastic surgery to remove excessive
44 skin folds should be paid for when her body mass index was normalised. That was her
45 motivation, to be operated and being able to wear bikini again. (Female resident)
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50 Detailed information about the patients initiated reflections among group members about the
51 complexity of many patients' lives, their self-efficacy and motivation for lifestyle change
52 despite these constraints. Several expressed respect and admiration of how their patients
53 managed ~~their~~ lives.
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7 It is actually fascinating how much power that might be hidden behind rather poor
8 facades. A complicated family situation, severe obesity, unemployment. Actually
9 problems from A to Z. (female partner)

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11 Some participants defended their patients if other group members criticised or made jokes
12 about ~~them~~their patients during case discussions. Paula, a female intern presented a case story
13 of a man taking anabolic steroids:

14 Ann: What kind of education or work did he have?

15 Paula: I don't remember.

16 Ann: Security guard, maybe?

17 Mike: You are rather stereotype!

18 Ann: No, do you think he had any education?

19 Paula: No, I don't think so, but he was employed in sales business. He seemed quite
20 bright when I talked to him.
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24 In other situations, the doctors supported each other's denigration of patients, ~~and made jokes~~
25 ~~about them~~. Some case stories included patients who did not comply with the doctors'
26 proposals, even when non-compliance would imply a serious threat to the patient's health.
27 The participants commented on how patients fooled themselves, made unwise decisions or
28 proposed too easy solutions to solve complex problems. A group of partners discussed
29 patients' self reported dietary habits:
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31 Kate: The problem was that she ate next to nothing. She did everything right.

32 Peter: It's amazing. All of my obese patients belong to the group that tell they never
33 eat much.

34 Rose: They know they are lying.

35 Peter: Just let them write down what they eat for three days. Make an agreement
36 about three normal days.
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40 *Reflections about the professional role*
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42 The case stories initiated discussions of meta-perspectives. The participants commented on
43 the storyteller's professional behaviour, and how this behaviour affected the consultations and
44 the patients. The participants shared professional knowledge concerning medical ethics and
45 the need to tailor counselling to each patient. Stories about consultations that failed led to
46 ~~elicited~~ discussions about how to elicit the patient's agenda, the fear of provoking distrust,
47 and the problem of unintended intimidation of patients when approaching the patients' deeply
48 rooted habits.
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51 Maybe you do everything right. Then you end up by not giving him the responsibility,
52 in a way. In such a situation I would use the fatalistic part of me, and tell him that he
53 was responsible. Sometimes maybe we are too eager, and take the responsibility from
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7 the patient. (Male partner)
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10 *Peer support*

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12 Several participants told about counselling that failed. This comprised complex situations
13 when both the doctor and the patient despaired, but also consultations in which the doctors
14 made proposals or decisions they later regretted. Some expressed significant emotional
15 involvement and personal disappointment when communication failed, others told about their
16 own struggle with lifestyle. The participants shared frustration related to insufficient support
17 from specialized health care, reluctant patients, and difficulties in doctor-patient
18 communication. Discussing these narratives, peer group members offered care and support,
19 but they also gave constructive critique and suggested alternative solutions. They often
20 responded by telling about similar experiences, and argued that doctors should expect limited
21 success in ~~complex~~ consultations with patients with complex problems:
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24 Rose: I thought about it after she had been there, that fifteen or twenty minutes - she
25 should have fifteen or twenty minutes to solve each of those problems.

26 Jane: It can be too much for a family physician, when specialist health care tells you
27 to follow up every patient.

28 Edith: But we should not solve everything. I have low ambitions about solving other
29 people's health problems.
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33 *Informal associations*

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35 The informal atmosphere in the peer-groups allowed spontaneous associations and proposals,
36 including suggestions about how to organise health care and ideas about alternative ways of
37 counselling patients. The participants joked and told anecdotes, triggered by the case
38 discussions and associations-personal experiences from their own private and professional
39 life. A group of residents discussed repetitively reminding patients to quit smoking:
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42 Eric: Just mention smoking when they come in. I think it enhances motivation in the
43 long run. My dentist has asked me every year if I use fluoride, and I don't. But
44 the last two months I have used it, because he asked again. He has not done
45 anything but ask me every time I met him.

46 Ruth: Same with me, but I have not managed yet.

47 Peter: Isn't it better to use dental floss?

48 Eric: But who uses dental floss?

49 Ruth: I'm thinking about it (laughter).
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53 **Discussion**

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Short summary of the main findings

The storyline of case presentations in focus groups included detailed stories with emotional engagement and co-authoring from other group members. The group interaction initiated discussions about the patients' and doctors' behaviours and agendas in the consultations, ethical implications and the handling of clinical problems in everyday practice. The case stories inspired group members to reflect upon the complexity of counselling and the doctors' roles. The participants offered each other constructive critique and peer support.

Strengths and weaknesses

The presence of the researchers in the focus groups may have influenced what group members chose to tell. ²³²⁴ To reduce this influence, the conductor chose a withdrawn position, and seldom interrupted the group discussions. Being a peer may elicit information that would not be told to a researcher with a different background, ²⁴²⁵ but may also cause blindness to aspects of the discussions that a researcher with different background would see. This was compensated to some extent by the presence of an observer with another professional background. The group members knew each other quite well, and we conducted the group sessions in a scheduled meeting. The participants discussed real case stories from their own practice. This strengthens the validity of the study. Video recordings would have provided more information about non-verbal communication, but also increased the possibility of information overload.

Dialogical interaction

Some of the case stories followed the traditional, succinct storyline of case presentation, while expansive stories represented a different genre, withenecompassing more focus on the patients' life context. We observed co-authoring during the expansive case presentations. In focus groups the audience may interact withsupply the speaker by verbal interruption, exclamations, supportive or confronting utterances, and by non-verbal communication. The speaker may address the whole group, or a selected person. Moments of 'split floor' discussions occur when different subgroups speak together. Pand polyphonic discussions occur when several participants take part in the same discussion. There may be moments of silence when ,as well as moments in which nobody wants or dares to 'take the floor'. ²⁵²⁶ In this study we observed 'split floor' and polyphonic discussions, but never no long periods of silencemoments when nobody 'took the floor'. This may be because the participants knew each other well, and the topic was engaging.

Frames of interaction

Prepared, condensed presentations represents front stage communication, ²⁶²⁷ also described in studies of morning reports in hospitals. ²⁷²⁸ In front stage communication the 'actor' plays the expected role. Front stage communication can be presented to anyone. Detailed case stories with emotional engagement that admit uncertainty or failure, represent back stage

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communication.²⁶²⁷ This is not meant for outsiders, and ~~only occurs~~ only in a safe environment. Professional back stage communication is included in the hidden curriculum of medical education, ~~supports each group member and strengthens group affiliation.~~^{28,2929-30} Humans socialize into groups that share social knowledge and communication.^{30,3131-32} Peer groups of general practitioners share professional competence, experience and social roles. Socially shared knowledge is formed and maintained through dialogical communication, and shapes what is being spoken about and the manner by which contents are framed.⁷⁸ We observed that this influenced how group members spoke about patients, other professionals and governmental institutions.

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An arena for testing out communications strategies

We noticed spontaneous associations, jokes about patients and anecdotes about controversial behaviours of doctors, reflecting an informal, supportive back stage atmosphere and group affiliation. We also observed attempts to try out controversial statements. Testing out the limits of acceptable behaviour is a frequent strategy in dialogues. While people talk to each other, they simultaneously carry out internal dialogues ~~with themselves or others to~~ prepare for positioning themselves in the discussion.⁷⁸ A participant may not wish to reveal her true opinion, be humiliated or step out of the group. This can be solved by using incomplete utterances, jokes, quoting 'third parties' and prompting for collaborative utterances.³²³³ Disrespectful comments about patients in some instances initiated constructive critique and a reminder of the ethical behaviour. The discussions addressed moral perception and the ability to identify ethical aspects in clinical situations.³³³⁴ Some participants ~~talked~~ told about their own struggle with lifestyle. Several narratives concerned counselling that failed. The group members ~~obviously~~ trusted each other, and utilized the peer group as an arena of debriefing and peer support. Brondt et al ~~found~~ showed that participation in peer groups as part of CME was associated with decreased risk of professional dysfunction among Danish GPs.³⁴³⁵

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Facilitating person-focused care

The atmosphere in the focus groups was supportive. The participants presented and discussed case stories in a cautious tone. By presenting their stories, they also presented themselves, thereby putting their own engagement at stake. The participants discussed patients' behaviour on a distanced level, but also demonstrated close, personal emotional involvement in patients' life world, and intentions of exploring patients' agenda. A distinction exists between patient-centred care and person-focused care. The latter has a (much) broader, encompassing focus. Person-focused care is based on accumulated knowledge of individuals/people, which provides the basis for better recognition of health problems and needs over time, and facilitates appropriate care for these needs in the context of other needs.^{35,3636-37} We have used the concept 'case-based thinking' to signify how a case-based ~~narrative~~ approach expands the emphasis on medical knowledge and the clinical medical problem in question, to encompass the context and the, personal and emotional involvement where only thin layers of distance exist between the general practitioner and the patient. ~~A distinction exists between patient-centred care and person-focused care. The latter has a much broader, encompassing focus.~~

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~~Person focused care is based on accumulated knowledge of people, which provides the basis for better recognition of health problems and needs over time, and facilitates appropriate care for these needs in the context of other needs.~~³⁶⁻³⁷ Dialogues among GPs based on 'case-based thinking' may have consequences for how GP relate to the clinical problem in question, and to how disagreements are solved. We only observed moderate competition about being right, and the group members often asked each other for advice. They often reached mutual agreement, and discussed ethical implications of their actions.

Implications for practice and research

The ~~case stories led to group interaction initiated~~ discussions about best practice, and exchange of ~~useful practical~~ tips. The starting point of the discussions was not theory or ~~research~~ evidence, but clinical experience. However, in some situations the participants referred to clinical guidelines to solve disagreements. Peer group meetings are suitable for introduction of attempts to improve practice skills.^{37 38 39} The storyteller tradition of case stories put clinical problems into context, and seemed to promote mutual reflections about counselling that might enhance meaning-making and reflective practice.^{39 40} We still need more information about how doctors think and learn, and how they develop and change clinical skills. Such information is available from peer groups of doctors.

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Conclusion

Presentations and discussions of case stories in peer groups of general practitioners followed a detailed storyline, and initiated dialogues that highlighted patients' perspectives and facilitated learning, discussions of best practice and reflections on medical ethics. The safe backstage atmosphere permitted the general practitioners to expression of emotions and, peer support, and to testing out ideas and opinions. The interactions facilitated sense-making and meaning-making ~~and activity that~~ influenced socially shared knowledge within the group.

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Competing interests None

Contributors EA and PS prepared the study protocol. EA collected the data. All authors were involved in analysis, interpretation and drafting the manuscript. EA is the guarantor.

Ethical approval The study did not involve patients. The doctors presented all case stories anonymously. The Regional Committee for Ethics in Medical Research regarded the study not to be within their mandate. All participants signed a declaration of informed consent before participation.

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