Masteroppgave

Empowerment og helsefremmende arbeid
Mai 2020

Økt mestring hos pasienter med kronisk lungesykdom under et tverrfaglig lungerehabiliteringsopphold:

perspektiver fra helsepersonell og pasienter

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FORORD

Denne masteroppgaven markerer slutten på en flott studietid ved OsloMet – storbyuniversitet. Å skrive masteroppgave har vært en både spennende, lærerik og utfordrende prosess. Studiet Empowerment og helsefremmende arbeid har bidratt stort til at jeg har fått mye ny kunnskap, som jeg ser frem til å benytte meg av videre.

Det er mange jeg ønsker å takke i forbindelse med dette masterprosjektet. Først så ønsker jeg å takke alle deltagerne som har vært med i studien. De satte av tid til å dele sine erfaringer og historier, noe jeg setter stor pris på.

Tusen takk til min veileder, Kristin Halvorsen. Ditt engasjement, faglige råd og motiverende tilbakemeldinger har bidratt stort til at jeg har klart å holde motivasjonen oppe gjennom hele prosessen. Jeg ønsker også å takke min medveileder, Cesilie Meling Stenbakken for at du har bidratt med gode tilbakemeldinger og oppmuntrende ord gjennom utarbeidingen av artikkelen. Deres støtte har betydd mye for meg!

Jeg vil også rette en stor takk til min medstudent, Heidi Mandt Lang-Ree. Takk for et flott og givende samarbeid, og for at jeg har fått lov til å dele min frustrasjon med deg når det har vært behov for det. Denne prosessen hadde ikke vært det samme uten deg.

Sist men ikke minst, tusen takk til familie, venner og andre medstudenter som har kommet med positive og oppmuntrende tilbakemeldinger. Dere er gode å ha!

Oslo, mai 2020

Caroline Steen Abrahamsen

INNHOLDSFORTEGNELSE

INTRODUKSJON TIL LESEREN

Denne masteroppgaven har blitt gjennomført i samarbeid med medstudent Heidi Mandt Lang-Ree. Vårt studentsamarbeid har resultert i to individuelle artikler, og en felles refleksjonsoppgave. Vi har skrevet hver vår individuelle artikkel om samme hovedtema, men artiklene er skrevet fra ulikt perspektiv. Artikkelen jeg har skrevet er basert på pasientenes perspektiv, og artikkelen til Heidi ser på tematikken fra helsepersonell sitt perspektiv. Refleksjonsoppgaven er utarbeidet i fellesskap, og studentsamarbeidet blir utdypet ytterligere i refleksjonsoppgaven. Artikkelen til medstudent Heidi ligger som vedlegg.

SAMMENDRAG

Bakgrunn: Tverrfaglig lungerehabilitering bidrar til at pasienter med kols opplever økt mestring og forbedret livskvalitet. Likevel er det begrenset forskning på hvordan og hvorfor tverrfaglig lungerehabilitering faktisk bidrar til at pasientene kan mestre sin hverdag.

Hensikt: I forskningsartikkelen var hensikten å undersøke ulike erfaringer som bidrar til økt mestring for pasienter med kols innlagt til lungerehabilitering, fra pasientens perspektiv. Hensikten med refleksjonsoppgaven var å reflektere rundt fokusgruppeintervjuer med hovedvekt på rollen som moderator, intervjuenes gruppedynamikk og gjennomføring av masterarbeidet med en medstudent.

Teoretisk forankring: Forskningsartikkelen benytter seg av teori om mestringstro. Refleksjonsoppgaven baserer seg på relevant litteratur og forskning knyttet til fokusgruppeintervju som metode.

Metode: Det empiriske arbeidet i studien benytter kvalitativ metode, med fokusgruppeintervjuer. Refleksjonsoppgaven baserer seg på relevante søk på aktuell forskning og litteratur.

Resultater: Fire hovedtemaer fremkom: tilegne seg nyttig verktøy til sin verktøykasse, møte mennesker i samme situasjon, bli sett på som et helt menneske og respektert av helsepersonell og forberede til livet etter rehabilitering. Refleksjonsnotatet viser blant annet at gruppedynamikk og moderatorrollen kan påvirke datamaterialet.

Konklusjon: Tverrfaglig lungerehabilitering øker pasientenes opplevelse av mestring ved blant annet at pasientene tilegner seg økt kunnskap, og møter mennesker i lignende situasjon. Å ha en individuell tilnærming, samt fokusere på hjemkomst viser seg å være av stor betydning. Refleksjonsnotatet har ført til økt bevissthet knyttet til gjennomføring av fokusgruppeintervjuer, samt at studentsamarbeidet kan ha hatt påvirkning på datamaterialet.

Nøkkelbegreper: lungerehabilitering, tverrfaglig samarbeid, mestring, kols, fokusgruppeintervju

ABSTRACT

Background: Interdisciplinary pulmonary rehabilitation is proven to increase patients with COPD´s coping abilities and quality of life. Nevertheless, there is limited research regarding why and how interdisciplinary pulmonary rehabilitation actually supports patients to cope with their illness.

Aim: To investigate experiences contributing to increased coping for patients with COPD during an interdisciplinary pulmonary rehabilitation, from a patient’s perspective. The reflection paper aimed to reflect upon the implementation of focus group interviews with emphasis on the moderator role, group dynamic within the interviews and the student collaboration.

Theory: The research article utilizes a theory of self-efficacy. The reflection paper is based on relevant literature and research.

Methods: Qualitative method with focus group interviews. The reflection paper is based on relevant literature and research regarding focus group interviews.

Results: Four themes emerged: adding tools to your toolbox, meeting people in the same situation, to be seen as a whole person and respected by healthcare professionals and preparing for life after rehabilitation. The reflection paper shows that group dynamic and the moderator role can influence the data.

Conclusion: Interdisciplinary pulmonary rehabilitation is useful regarding patients coping abilities due to achieving increased health competence and meeting people in a similar situation. Having an individual approach and focusing on returning home seems to be of great value. The reflection paper has led to increased awareness related to conducting focus group interviews. In addition, the student collaboration may have had an impact on the data.

Keywords: pulmonary rehabilitation, coping, COPD, interdisciplinary collaboration, focus group interviews

UTFORMING AV ARTIKKELEN

Forskningsartikkelen er skrevet med tanke på publisering i tidsskriftet “Journal of Clinical Nursing”. Dette er et internasjonalt, fagfellevurdert, vitenskapelig tidsskrift som søker å fremme både utvikling og utveksling av kunnskap som er direkte relevant for alle områder av sykepleiepraksis. I tillegg er tidsskriftet også interessert i kunnskap knyttet til tverrfaglig samarbeid, og det er ønskelig med bidrag fra annet helsepersonell.

Retningslinjene for publisering i tidsskriftet viser til at det er en maksgrense på 8000 ord. Abstraktet skal være på maksimalt 300 ord. Øvre grense på referanser er 50 stk. Referansestilen som benyttes er American Psychological Association (APA). Fullstendige retningslinjer for tidsskriftet ligger vedlagt.

Patients with COPD: Experiences of increased coping during an interdisciplinary pulmonary rehabilitation.

A qualitative focus group study

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ABSTRACT

Aims and objectives: To investigate experiences contributing to increased coping for patients with COPD during an interdisciplinary in-hospital pulmonary rehabilitation.

Background: Patients with COPD often have difficulties accepting their own life situation, reduced activity level and low social interaction. Despite the amount of research combined to interdisciplinary collaboration and coping, there is limited research on patient perspectives regarding why and how pulmonary rehabilitation actually supports patients with COPD to cope with their illness.

Design: Qualitative design.

Methods: The data consists of qualitative focus group interviews with 17 participants, divided into three focus groups. The data were analyzed using thematic analyses.

Results: The patients described a lack of knowledge and understanding of their illness. In addition, patients felt limitations due to their lifestyle and social interaction. Support from healthcare professionals during pulmonary rehabilitation was proven vital, yet the lectures and consultations were described as general, and carried out too quickly. The patients mentioned a positive effect regarding being on pulmonary rehabilitation, however they stated the feeling of loosing motivation when returning home.

Conclusion: Findings indicate that gaining a better health competence during pulmonary rehabilitation has contributed to increased coping for the patients. Moreover, meeting people in a comparable situation and feeling respected by healthcare professionals has proven to be of great value. Nevertheless, having an individual empowerment-oriented approach, and focusing on returning home, seems to be significant in relation to patients increased and lasting coping after pulmonary rehabilitation.

Relevance to clinical practice: Patients with COPD should be offered pulmonary rehabilitation, considering that it proves to have a positive effect on coping abilities. Different measures regarding follow-up after pulmonary rehabilitation is vital due to maintaining motivation after returning home.

Keywords: pulmonary rehabilitation, coping, chronic obstructive pulmonary disease, interdisciplinary collaboration.

1 INTRODUCTION

The rising prevalence of chronic lung diseases is becoming an increasingly frequent health problem globally, and is therefore of high relevance. Chronic Obstructive Pulmonary Disease (COPD) is an under-diagnosed, life-threating lung disease, and is predicted to become the third leading cause of death worldwide by 2030 (World Health Organization (WHO), 2020). In this study, COPD is used as an umbrella term to describe chronic lung diseases that cause difficulties in lung airflow. In Norway, more than 250.000 people have been diagnosed with COPD (The Norwegian Directorate of Health, 2012). The disease is characterized by persistent respiratory symptoms, and the main common symptoms are chest tightness, wheezing, breathlessness and chronic cough (Global Initiative for Chronic Obstructive Lung Disease (GOLD), 2020). Previous studies indicates that pulmonary rehabilitation (PR) increase patient´s quality of life, rise the level of functioning, reduce deterioration and diminish needs for hospitalizations (McCarthy et al., 2015; Ryrso et al., 2018). PR is a comprehensive intervention that includes health education, exercise training, behavior change and breathing techniques for patients with COPD. The intervention should be personalized to the unique needs of each patient, based on complexity, disease severity and comorbidities (Spruit et al., 2013). In order to provide such, an interdisciplinary collaboration is essential. An interdisciplinary collaboration utilizes the approach of different healthcare professionals with a distinguished level of communication and collaboration among them, with both common goal-setting and decision-making (Singh, Kucukdeveci, Grabljevec, & Gray, 2018). An interdisciplinary team may consist of e.g. doctors, nurses, physiotherapists, occupational therapists, social workers and clinical nutritionists.

2 BACKGROUND

Previous research expose that patients suffering from COPD often have difficulties accepting their life situation, and often experience both reduced activity levels and low social interaction (Jerpseth, Dahl, Nortvedt, & Halvorsen, 2018; Marx et al., 2016). In a relevant qualitative study by Harrison et al. (2015), the results indicates that patients with COPD often felt concerned about other´s evaluation of their own behavior, which in turn could lead to social isolation. In the same study, the participants appeared reluctant to accept external support, due to the fact that earlier interactions with healthcare professionals was perceived as both critical and judgmental. A review by Disler et al. (2016) reported that PR is an important approach in promoting patient empowerment. Empowerment refers to the process of increasing patients´ confidence, knowledge and skills, allowing them to influence their environment in a certain way that strengthen their own well-being (Kemm, 2015). Nevertheless, and very unfortunately, several patients experience a decline in physical activity after PR (Robinson, Williams, Curtis, Bridle, & Jones, 2018; Spruit et al., 2013; Stewart et al., 2014). This may be related to patients not maintaining an equally high level of activity after PR and are unable to preserve motivation when returning home (Hogg, Grant, Garrod, & Fiddler, 2012).

A systematic review of qualitative research focusing on the barriers and facilitators from the perspectives of patients with COPD concludes with the importance of prioritizing psychosocial needs, in order for patients to cope with their everyday lives (Russell et al., 2018). A patient´s physical, social and emotional care needs is often closely associated with each other. Both within Norwegian political documents and previous research, interdisciplinary collaboration within healthcare is seen as an approach to promote coping as an important aspect in treatment and care for people with COPD (Fotokian, Mohammadi Shahboulaghi, Fallahi-Khoshknab, & Pourhabib, 2017; Paap, Bode, Lenferink, Terwee, & van der Palen, 2015; Singh et al., 2018).

3 THEORETICAL FRAMEWORK

There are several different definitions of coping within health. Coping can, among other things, be about achieving something new that you did not manage before. Additionally, it can also be related to more easily accepting one´s own life situation. These thoughts are inspired by various theoretical perspectives, including the previous work and research of Albert Bandura. Bandura (1997) emphasized the importance of a person's own belief of personal efficacy. He stated that unless people actually believe they can make some positive effects by their own actions, the people have little incentive to act in the first place.

4 AIM

Despite the amount of research combined to interdisciplinary collaboration and coping, there is currently limited research on patient perspectives regarding why and how interdisciplinary collaboration in PR actually support patients with COPD to cope with their illness. The aim of this study is therefore to investigate experiences contributing to increased coping for patients with COPD during an interdisciplinary in-hospital pulmonary rehabilitation.

5 METHOD

5.1 Design

This is a qualitative focus group interview study. Focus groups was chosen as the study aimed to get a deeper understanding of the participants' own experiences (Brinkmann & Kvale, 2015). According to Morgan (1997), qualitative methods have commonly been used when wanting to get a greater understanding of why people act in different ways. Further on, Morgan explains how the method highlights various human experiences, such as thoughts, emotions, expectations and attitudes, which is essential in this study.

5.2 Setting

The study was conducted in a Norwegian hospital that provides rehabilitation services to patients with COPD. The focus group interviews were held during November to December 2019. Patients with COPD from all over the country can be referred to four weeks in PR, and they can apply for a stay at any time during the course of illness. The PR offers various types of rehabilitation, such as rehabilitation for early lung disease, work-oriented rehabilitation and rehabilitation for advanced lung disease.

5.3 Participants and recruitment

A purposive sampling procedure was chosen to obtain rich descriptions of the individuals' experiences. The sampling procedure aimed to establish a participant variation by including people with different ages, sexes and diagnosis that participated in the various types of rehabilitation. A leading physiotherapist at the hospital recruited the patients. The inclusions criteria were that the patients had COPD and were involved in rehabilitation at the PR. Both genders at the age of 18-85 were included. Additionally, the participants had to speak Norwegian. Three focus groups were conducted, and each group met for approximately 60-80 minutes. There were a total of 17 participants, six women and eleven men as shown in table 1. One of the participants was at 18 years of age, and the remaining ones were 50-85 years old. The participants had various types of COPD, and there was considerable variation in the course of illness. Participants were given a consent form by the recruiter. The ones that agreed to participate signed and returned the consent form before the interview started.

TABLE 1 Characteristics of the 17 participants

Gender	
Female	6
Male	11
Age, years	
Range	18-85
Mean	64

5.4 Data collection – focus group interviews

Focus groups were used to produce an in-depth understanding of experiences contributing to increased coping for patients with COPD during PR. The aim of the focus group interviews was to encourage a variation of viewpoints on the topic being discussed. Discussions through focus groups can be helpful when identifying both different and similar experiences among the participants, and to encourage the participants to respond to different point of views that will be raised in the group (Brinkmann & Kvale, 2015). According to Morgan (1997), the trademark of focus groups is the interaction to produce insights and data. Without the interaction in the groups, this information would be less accessible, and therefore the participants were encouraged to both discuss and comment each other´s thoughts and experiences.

A semi-structured interview guide was developed prior to the interviews. The focus group interviews were audiotaped and transcribed verbatim shortly after each session by the first author. The moderator (first author) is a social worker that has previous experience of working with patients who has a chronic disease, and the assistant (second author) is a physiotherapist. All focus groups were led by the moderator, and the assistant were present each time. Focus groups took place in a meeting room at the PR. During the interviews, we tried to promote an open atmosphere, allowing personal experiences and unexpected statements to be shared in the group.

5.5 Data analysis

To address significant aspects of the themes that the participants outlined during the focus group interviews, the data were analyzed by the first and third author, and discussed among all authors. The six-step thematic analyses as explained by Braun, Clarke, Hayfield, and Terry (2019) were used. The intention of a thematic analysis is to identify patterns and themes within the qualitative data.

The first step in our analysis involved reading, and re-reading the transcripts while being thoughtful and curious about the data. In step two, the data were organized in a systematic and meaningful way. This coding phase is about being focused in order to systematically make sense of data. Each transcript was examined through open thematic coding. This process involved organizing the data into similar codes and meanings. Constructing themes continues in phase three, where the codes were examined to see if some of them clearly fitted together. At the end of this step, the codes had been organized into broader themes that were relevant for the research question. If some of the statements were perceived as overlapping, they were placed under more than one theme. The next analytical step involved reviewing, developing and modifying the themes from step three and considered whether the data really did support the selected themes. The purpose of the fifth step was to define themes, and to make sure that the names of the final themes reflected the results. We sought out what the themes really were about and ensured that the themes, and theme names, clearly captured the data in a meaningful way. The last step was the writing-up, were it was made sure that the themes remained in proximity to the dataset, and answered the research question.

5.6 Research ethics

The study was reported and approved by Norwegian Centre for Research Data (NSD), and the data protection officer at the hospital, in autumn 2019.

6 RESULTS

Four themes that reflect the patients` experiences of increased coping during PR were identified: adding tools to your toolbox, meeting people in the same situation, to be seen as a whole person and respected by healthcare professionals and preparing for life after rehabilitation.

6.1 Adding tools to your toolbox

The results in this study revealed that the participants acquired much new knowledge and understanding of their illness during PR. This relates, among other things, to the doctor consultations where they received an updated status on their health situation. Additionally, they benefited much from participating in the various healthcare professionals´ lectures on different relevant topics. The participants added in different ways new tools to their toolbox for better coping. One important tool was gaining a better health competence about the illness, its challenges, possible treatment options, and very important; how to improve life with COPD.

In general, the participants described a feeling of more competence related to their illness leading to a better understanding regarding the challenges that occur with COPD. Attaining a new perspective on their lifestyle made it easier to accept their illness and the limitations it brings. Many participants emphasized that the more they accepted their illness, the more they became aware of the things they also mastered, and they dared to push themselves further. As one participant said:

> You have to dare to push your own boundaries. Many people with this disease are afraid to challenge themselves because you start breathing heavily right away and you feel completely broken and tired. But it is possible to stretch the boundaries much longer before you are dead! It often works better than assumed (Participant 4, focus group 2).

Even though most participants repeatedly stated the importance of getting good and content-rich information as important for them, some mentioned that the lectures held by healthcare professionals were sometimes too general. One participant expressed that she *"felt the lectures were not specifically tailored to her diagnose".* Those participants who had a more rare type of COPD in particular supported this. The participants agreed on the importance of getting a doctor consultation, yet described the consultations as often being too short, and not having the patient-centered and individual approach they wanted. One participant described it as such:

> It is very important that you dare to speak up, and dare to ask questions during the consultation. Otherwise, you will not get any answers. The doctors here do not have enough time to talk to you. They are constantly belated (Participant 5, focus group 3).

6.2 Meeting people in the same situation

The participants emphasized the importance of meeting, and talking to, people in the same situation as themselves. One of the participants described a feeling of *"not being alone with his problems in this world".* Furthermore, the participants agreed upon the importance of sharing both thoughts and feelings with others, and that social comparison to others with COPD had a positive impact on their perception of themselves.

Interaction with others with COPD during PR, particularly through support groups and casual conversations in the hallway, offered a sense of validation of one´s own experiences. Several of the participants mentioned that it was good to be able to talk about more sensitive topics with others, and the subjective experiences of having a chronic disorder:

> The fact that we can talk to other patients here helps me a lot. To share experiences with patients with the same illness and listen to how they solve their problems and challenges… its remarkable. There are themes that appear in the groups, which I have thought of myself, but not talked to others about... and then there are many others sitting there, who also thinks the same. It has been a very positive experience for me (Participant 4, focus group 3).

A feeling of not being completely understood by their closest relatives when at home was something the participants mentioned as difficult to cope with. The participants claimed they have had challenges regarding talking to their friends, family or colleagues about their illness, which often resulted in social isolation at home. One participant said that she *"often had been labeled as lazy by her loved ones",* and got comments about never doing anything useful during the weekdays because she always slept a lot. Among other things, such comments and approach from others towards the participants has had a negative impact on their confidence, social life and job situation. One of the participants mentioned that when he started to walk around with an oxygen tank visible at work, he described a feeling of discrimination from his colleagues, due to efficiency at the workplace:

> When I first started with oxygen, I felt a lot of pressure from the workplace. I felt like they were trying to figure out how to get rid of me somehow. They made me feel very handicapped (Participant 2, focus group 1).

6.3 To be seen as a whole person and respected by healthcare professionals

Several of the participants emphasized feeling respected by the healthcare professionals during PR. They sensed that the healthcare professionals worked well together regarding the participant's various needs, which was a feeling the participants agreed on not having felt before. Some of the participants experienced the importance of several professional groups being available at the same place, e.g. nurses, occupational therapists and social workers. Furthermore, they appreciated that the healthcare professionals at the PR really focused on all the challenges they had, both physically and mentally as the quotation below underline:

> Well, here they suggest that we can both focus on the physical, in relation to for example medicine and exercise, but they also suggest that we can talk about.. well.. the mental stuff! They have organized it so we can participate in conversation groups! And they help us understand how these different aspects of our illness affect each other (Participant 2, focus group 1).

The importance of healthcare professionals at the PR having a holistic approach to health care was something the participants repeatedly mentioned as positively influencing daily life. They specified previously feeling like a small piece in the otherwise substantial big health care system, and that they have had the impression of fragmented services. The participants further pointed out that there were some healthcare professional groups they were more in contact with than others during the PR, e.g. nurses and physiotherapists. In addition, it emerged that not all participants knew what the various healthcare professional groups could offer of information and services. One participant mentioned that she had been offered a conversation with a social worker, but that this offer came towards the end of her stay at the PR. This was expressed as stated in the quotation below in one of the focus groups:

> Social workers should get in touch much earlier! They should look at the age group of the participants, and get into the process at an early stage. Instead of coming in at the last minute (Participant 3, focus group 2).

6.4 Preparing for life after rehabilitation

Preparing for the life outside PR was another theme discussed in the focus groups, and experienced as important by the participants. They talked about challenges concerning making daily life work. However, one of the participants had already received help by the healthcare professionals in the PR to make an arrangement so she would receive the follow-up she needed when returning home. This were described as such:

> So.. I will get a visit from someone, someone to talk to. At home. Because when I said that I felt very isolated, they fixed it for me… someone to talk to. There will also be a physiotherapist, who I could start exercising with. Obviously it helps to have someone to push you a bit (Participant 1, focus group 3).

In general, the participants mentioned that they were worried about coming home, because it was easier to maintain good routines while they were in PR. Although they were a bit concerned, they all felt motivated to maintain the positive routines when returning home. However, some participants pointed out that they had been on several PR stays before, and they agreed on the feeling of often loosing motivation when they returned home. Furthermore, it was pointed out by those who had been on PR previously, that they appreciated the opportunity to come back for another stay in order to be entirely focused again. One of the participants stated:

> So, the bend will be when I get home. Because there, in a way, I have to manage completely on my own, without this supportive environment. So I really hope I can be able to maintain my workout routines when I get home (Participant 6, focus group 3).

7 DISCUSSION

This article sought to achieve an understanding of which experiences patients with COPD has that contributes to increased coping during an interdisciplinary in-hospital PR. The findings indicate that patient´s understanding and knowledge of COPD often were reported as limited, but that this improved during PR. New knowledge and updated information regarding their disease made patients feel safer, and they dared to push their limits further. Patients with

COPD having inadequate health competence about their illness are supported by other studies (Jerpseth et al., 2018; Russell et al., 2018). Some of the participants in our study emphasized that lectures held by healthcare professionals during PR were too general and not particularly disease specific. For instance, one participant mentioned that the lectures mainly focused on COPD as one disease, however the patients suffered from e.g. lung fibrosis and lung cancer. The PR in which the data collection was conducted has different courses for different participants, depending on lifestyle, course of disease and so on. The lectures were, however, common to all patients, and this may explain why some participants perceived as such. As the findings reveal, it is important for patient outcome that the PR is tailored specifically to each individual diagnose. This may indicate that combining user-involvement into the planning of PR can be of great value in order to individualize the PR-programs, to achieve positive patient-centered outcomes. User-involvement is an important and growing theme supported by health policy documents globally, where the goal is to make the users of healthcare an active partner (Halvorsen et al., 2020). In relation to user-involvement, a more patient-empowered orientation could be convenient in order to increase patient´s confidence and health competence (Halvorsen et al., 2020; Kemm, 2015). Moreover, our data support that being focused on user-involvement and having an empowerment-orientated approach during PR could be of great value in relation to increased coping for patients with COPD.

Our findings, supported by existing research by e.g. Jones, Hamilton, and Murry (2015) and Russell et al. (2018) reveal that medical consultations often were experienced as not having the patient-centered and individual focus the participants wished for. In addition, it was stated that the consultations often were carried out too quickly. It is a general and well-known phenomenon that one often feels that both doctors and other healthcare professionals, e.g. nurses, physiotherapists or clinical nutritionists, has limited amount of time to see each patient during a consultation (Scott et al., 2019; Young et al., 2015). All though there is an increasing emphasis on efficiency in health care delivery, the quality time between healthcare professionals and patients is a likewise increasingly valuable resource (World Health Organization (WHO), 2018). A healthcare professional with a busy schedule at work can be seen as an indication of why consultations often fall short (Jones et al., 2015). Perhaps the healthcare professionals have too limited time, and that the timeframe stands in the way of being as patient-centered as desired. However, we can draw lines to the positive aspect of being on PR. In PR, all the healthcare professionals have interdisciplinary meetings where they focus on the holistic side of the patients regardless. In accordance with our findings, an interdisciplinary team appears to be valuable for providing relevant information and good collaboration, in order to address each patient´s various needs (Jones et al., 2015; Russell et al., 2018; Scott et al., 2019; Young et al., 2015).

During PR, it becomes natural that healthcare professionals who have a great influence on medical treatment, e.g. doctors, nurses and physiotherapists, have a correspondingly substantial role for the benefit of the patients. However, this may results in other healthcare professionals getting less participation in the interdisciplinary collaboration (Goldsmith, Wittenberg-Lyles, Rodriguez, & Sanchez-Reilly, 2010). This corresponds with the results of our study, where several participants pointed out that there were some healthcare professionals they were more in contact with than others during the PR. A consideration regarding the age difference of participants in our study could be of relevance in this matter. The age difference is quite widespread, which is a general case in various PR´s. The need for a conversation with different healthcare professional groups will naturally vary from patient to patient. All human beings are individual, and there will likewise always be different needs based on e.g. one´s resources, such as economy or social network. Previous research indicates that professional groups who are marginalized in their workplace, may more often experience a feeling of not being as involved in the collaboration regarding the patient as desired (Goldsmith et al., 2010). This highlights the importance of capturing the different needs of each patient during the PR, in order to be as patient-centered as possible. The results in our study reveal that one of the participants felt that the social worker got in contact with her quite late during the PR. The PR has a continuing intake, which implies that patients have different schedules, and participate in the various lectures held by healthcare professionals at varying times during their stay. For some, the lectures may come closer towards the end of the PR. Due to a participant expressing such feelings, this might raise questions of how the interdisciplinary collaboration at the PR is carried out in practice.

Sharing experiences with people in the same situation as oneself was reported as important during the focus group interviews. This is in line with Bandura's (1997) theory of self-efficacy, which emphasizes that hearing about others' experiences can contribute positively to one´s own sense of mastery. In line with Marx et al. (2016), the results in our study promotes that people with COPD often feel both social isolation and increased physical burden, which are known as basis for decreasing social and psychological well-being (Harrison et al., 2015). Several different factors may have an impact on social isolation. Our participants talked about not being understood by their loved ones, while other studies indicate that patients often compare themselves to other seemingly healthy people (Harrison et al., 2015; Marx et al., 2016). According to the theory of self-efficacy, it is stated that if you experience failure, your motivation will likewise decrease (Bandura, 1997). If patients with COPD constantly compare themselves with ostensibly healthy people, this could lead to a negativ impact on one´s self-image, in contrast to if they compare themselves with people who are in resemblant situations.

Not only does self-efficacy influence behaviour directly, it also shapes the expectations of outcome and perceived impediments (Kemm, 2015). In the findings of Steindal et al. (2017), some of the participants stated that they were not willing to use a portable oxygen tank outdoors, due to feeling embarrassed concerning their altered appearance. The study of Disler et al. (2016) indicates that the psychological impact of COPD led patients to live in an isolated world, which can be compared to the results of our study. One of the participants in our study felt discriminated by his workplace due to walking around with an visible oxygen tank. This may indicate that there is a barrier for patients with COPD to walk around with an oxygen tank in public. Thus, other findings support that some patients used a portable oxygen tank specifically to make their impairment visible (McMillan Boyles, Hill Bailey, & Mossey, 2010). Although participants felt accepted inside the walls of the PR, one can question whether it is being organized during the PR to focuse on the emotional barriers that can be encountered outside the hospital walls. The barriere of walking around with an visible oxygen tank can be related to the feeling of vulnerability and shamefullness regarding the fact that COPD is often viewed by society as a self-inflicted disease (Halding, Heggdal, & Wahl, 2011). Research argues that this has been shown to degenerate both in relation to one´s closest relatives, and in relation to healthcare professionals (Halding et al., 2011; Harrison et al., 2015). The participants in our study appeared sensitive to how peers and healthcare professionals viewed them, due to a feeling of stigmatization. This is in line with the study of Harrison et al. (2015). A fear of others´condemnation may encourage patients with COPD to have a defensive position, hereby leading to social isolation and a lower self-image. In order for the patients to maintain a sense of coping when returning home, it may be useful to prepare the patients for life after PR, to prevent them from falling back into old habits.

Preparing patients with COPD for life after rehabilitation is an important part of PR. Despite this, benefits of PR seems to diminish over 6-12 months (Hogg et al., 2012; Spruit et al., 2013; Stewart et al., 2014). This corresponds with the findings of our study. Being prepared for life after PR by adding new tools to one`s own toolbox, e.g. acquiring new knowledge about the disease, can increase patients self-efficacy and a sense of empowerment (Robinson et al., 2018). Furthermore, it may have an impact on facilitating a positive outlook for the future (Disler et al., 2016). Motivation is one of the major goals of PR (Spruit et al., 2013). Increased motivation may occur when patients experience positive benefits, and therefore self-efficacy beliefs is important in order to self-regulate one owns motivation.

We will argue that having an individual approach in PR, focusing on patient empowerment, hopefully could lead to increasing both patients confidence and health competence as an outcome. Furthermore, it may help patients with COPD to influence their own environment in a positive way that increases their own well-being and contributes to increased coping. In addition, the findings reveal that an interdisciplinary approach during PR has a positive effect on patients' ability to cope. The participants repeatedly mentioned that it was good to meet different types of healthcare professionals, who focus on the overall perspective of the patients, both mentally and physically. On account of the large variance of individual differences within patients with COPD, there is not one approach that fits all when it comes to obtain lasting behaviour change following PR (Robinson et al., 2018). This needs to be taken into consideration when tailoring PR programs to meet the individual needs for each patient.

8 STRENGTHS AND LIMITATIONS OF THE STUDY

The focus group study design allowed for an in-depth investigation regarding patients with COPD and their increased coping during PR. Focus group interviews can be affected due to the sensitive nature of the topic that are being discussed, and according to David Morgan (1997) some subjects may be better explored in individual interviews than in a group setting. In this particularly study, the participants had experience of being in groups talking about relevant topics such as coping with the disease, and focus groups were therefore seen as an advantage for this study.

To enlarge the validity of this study, both first and third author read the interviews independently. This led to rewarding discussions around the analysis and interpretation of the findings. A consideration that needs to be emphasized is that the interviews were conducted in Norwegian, and later on translated to English for the purpose of this research article. Brinkmann and Kvale (2015) suggest that when publishing the quotations, one should adjust the spoken language into written form. This should be done in order to give a clearer meaning of the quotations. Therefore, in the quotations, some words without a relevant meaning was edited out when translating. Despite this, these limited adjustments did not change the meaning of what the participants stated. Additionally, this study has a sample of 17 participants. The participants provided enough information in order to get a point of saturation, however a larger sample including more participants could contribute to even more knowledge.

9 CONCLUSION

Our findings indicate that achieving a better health competence has contributed to increased coping for patients with COPD during PR. Correspondingly, the importance of meeting people in a comparable situation and feeling recognized by healthcare professionals proved to be of significance. Furthermore, healthcare professionals having a holistic perspective and being accessible during the PR proved to be of great value for patients´ experience of increased coping. Patients with COPD are not a homogenous group, and therefore it becomes important to individualize the PR based on the various patient´s needs. Nevertheless, having an individual empowerment-oriented approach in PR, and preparing the patients for life after PR, seems to be significant in relation to patients increased and lasting coping after PR. Perhaps there should be an opportunity to get follow-up for the participants after completing PR, in order to maintain motivation? Further studies are required to clarify these issues.

10 RELEVANCE TO CLINICAL PRACTICE

This study provides valuable insight regarding experiences contributing to increased coping for patients with COPD during an interdisciplinary in-hospital PR. Considering that being on an interdisciplinary PR, and meeting people in comparable situations as one`s self proves to have a positive effect on coping, this is something that should be offered to all patients with COPD. As it proves to be challenging to maintain lasting behaviour change following PR, different measures are needed to obtain motivation. Measures such as digital follow-up or motivational sessions continuously after PR may be relevant in this matter.

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FORESPØRSEL TIL PASIENTER OM DELTAKELSE I FORSKNINGSPROSJEKT

TVERRFAGLIG SAMARBEID SOM ARENA FOR MESTRING HOS PASIENTER MED KRONISK LUNGESYKDOM

- perspektiver fra helsepersonell og pasienter

Dette er et spørsmål til deg om å delta i et forskningsprosjekt. I denne studien er hensikten å få økt kunnskap om hvordan et rehabiliteringsopphold med tverrfaglig fokus kan hjelpe pasienter med å mestre hverdagen med en kronisk sykdom.

HVA INNEBÆRER PROSJEKTET?

Studien vil undersøke hvilke erfaringer både helsepersonell og pasienter har med tverrfaglig samarbeid som tilnærming for å fremme mestring. I undersøkelsen vil derfor innhente opplysninger om deg og dine erfaringer med tverrfaglig mestringsarbeid. Datainnsamlingen vil bli basert på fokusgruppeintervjuer, hvor det er gruppeintervjuer med 5-8 personer. Intervjuene vil bli tatt opp med digital diktafon og lagret på lydfil, som deretter vil bli transkribert. Tekstmaterialet er grunnlaget for videre analyse og publisering av to vitenskapelig artikler. Studien vil gjennomføres fra august 2019 til mai 2020.

MULIGE FORDELER OG ULEMPER

Fordelen med studien er at i form av fokusgruppeintervju kan man dele tanker med andre, og man får selv belyst og snakket om opplevde erfaringer. Gjennom fokusgruppeintervju får man også mulighet til å høre andres erfaring om mestring, som kan føre til nye refleksjoner. Dette kan skape bevisstgjøring rundt mestring. En annen fordel er at dine tanker og erfaringer kan bidra til å styrke det tverrfaglige arbeidet i en rehabiliteringskontekst. Det kan også være vanskelig å dele erfaringer, fordi noe er sårt og vondt. Du bestemmer selv hva du vil dele. Det kan også være en styrke for deg å se at flere har det på samme måte og kunne drøfte hvordan vanskelige situasjoner mestres. Det vil tas hensyn til om du skulle bli sliten. Du kan avbryte intervjuet om du skulle ønske det og vi kan ta pauser.

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE SITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Dette vil ikke få konsekvenser for din videre behandling. Hvis du velger å delta, kan du når som helst trekke samtykke tilbake uten å oppgi grunn. Alle opplysninger om deg vil da bli anonymisert. Det vil ikke ha negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg. Dersom du skulle ønske å trekke deg eller har spørsmål til prosjektet, kan du kontakte prosjektleder Kristin Halvorsen, epost: kristin.halvorsen@oslomet.no, tlf: 922 16 250, Caroline Steen Abrahamsen, epost: s318494@oslomet.no, tlf: 41 47 75 04, Heidi Mandt Lang-Ree, epost: s196368@oslomet.no, tlf: 95 90 86 46.

HVA SKJER MED INFORMASJONEN OM DEG?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert. Du har også rett til å få innsyn i sikkerhetstiltakene ved behandling av opplysningene.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre gjenkjennende opplysninger. En kode knytter intervjuutskriftene til deg. En liste som kobler kode og navn vil oppbevares på kryptert og passordbeskyttet minnepinne, separat fra alle data, i låsbart og brannsikkert skap ved OsloMet.

Prosjektleder har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert, eller slettet senest fem år etter prosjektslutt. Så lenge du kan identifiseres i datamaterialet, har du rett til å få utlevert en kopi av dine personopplysninger (dataportabilitet), og sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

GODKJENNING

På oppdrag fra OsloMet har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket. Saksnummer NSD 121257.

KONTAKTOPPLYSNINGER

Dersom du har spørsmål til prosjektet kan du ta kontakt med prosjektleder Kristin Halvorsen, epost: kristin.halvorsen@oslomet.no, tlf: 922 16 250, Caroline Steen Abrahamsen, epost: s318494@oslomet.no, tlf: 41 47 75 04, Heidi Mandt Lang-Ree, epost: s196368@oslomet.no, tlf: 95 90 86 46.

NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller tlf: 55 58 21 17.

Personvernombud ved institusjonen er Ingrid Jacobsen, tlf: 993 02 316, epost: ingrid.jacobsen@oslomet.no.

SAMTYKKE TIL DELTAKELSE I PROSJEKTET

JEG ER VILLIG TIL Å DELTA I PROSJEKTET

Sted og dato	Deltakers signatur

INTERVJUGUIDE

Hvordan er det for dere å være her på rehabiliteringsopphold?
Hva legger dere i ordet mestring?
Hva legger dere i ordet tverrfaglig samarbeid?
Ser dere noen fordeler ved at det jobbes tverrfaglig her?
Ser dere noen ulemper ved at det jobbes tverrfaglig her?
Kan dere diskutere om dere har fått til noe nytt mens dere har vært på rehabiliteringen?
Å ha en kronisk lungesykdom, kan føre med seg ulike utfordringer. Føler dere at dere blir møtt på de ulike utfordringene dere har av de som jobber her?
Hva har vært det aller viktigste for dere under rehabiliteringsoppholdet?
Hva har dere opplevd som mindre viktig?
Hvordan bidrar det tverrfaglige teamet til at dere skal nå de målene dere setter dere?
Opplever dere at det tverrfaglige samarbeidet bidrar til å fremme mestring? - I så fall, hvordan? Diskuter
Er det noe annet dere ønsker å tilføye?

NSD sin vurdering

Skriv ut

Prosjekttittel

TVERRFAGLIG SAMARBEID SOM ARENA FOR MESTRING HOS MENNESKER MED KRONISKE LUNGESYKDOMMER - perspektiver fra helsepersonell og pasienter

Referansenummer

121257

Registrert

07.08.2019 av Kristin Halvorsen - kgroethe@oslomet.no

Behandlingsansvarlig institusjon

OsloMet - storbyuniversitetet / Fakultet for helsevitenskap / Institutt for sykepleie og helsefremmende arbeid

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

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Type prosjekt

Studentprosjekt, masterstudium

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Prosjektperiode

08.08.2019 - 31.12.2020

Status

21.10.2019 - Vurdert

Vurdering (1)

21.10.2019 - Vurdert

Prosjektet er vurdert av REK sør-øst B i vedtak av 14.10.2019, deres referanse 30335 (se under Tillatelser). REK vurderer at studien framstår som forskning, men ikke som medisinsk eller helsefaglig forskning. Prosjektet er følgelig ikke omfattet av helseforskningslovens saklige virkeområde, jf. helseforskningslovens §§ 2 og 4. Prosjektet vil derfor bli gjennomført og publisert uten godkjenning fra REK. Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet den 21.10.2019 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte når godkjenning fra personvernombudet ved LHL-sykehuset Gardermoen foreligger. Dersom vedtak fra personvernombudet ved LHL-sykehuset Gardermoen medfører endringer i prosjektet må dette meldes til NSD ved å oppdatere meldeskjemaet. MELD VESENTLIGE ENDRINGER Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde: https://nsd.no/personvernombud/meld_prosjekt/meld_endringer.html Du må vente på svar fra NSD før endringen gjennomføres. TYPE OPPLYSNINGER OG VARIGHET Prosjektet vil behandle særlige kategorier av personopplysninger om helseopplysninger og alminnelige kategorier av personopplysninger frem til 31.12.2020. LOVLIG GRUNNLAG Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og art. 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake. Lovlig grunnlag for behandlingen vil dermed være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a, jf. art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2). PERSONVERNPRINSIPPER NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om: - lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen - formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål - dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet - lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet DE REGISTRERTES RETTIGHETER Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19) og dataportabilitet (art. 20). NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13. Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned. FØLG DIN INSTITUSJONS RETNINGSLINJER NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32). For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og eventuelt rådføre dere med behandlingsansvarlig institusjon. OPPFØLGING AV PROSJEKTET NSD vil følge opp underveis og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/ pågår i tråd med den behandlingen som er dokumentert. Lykke til med prosjektet! Kontaktperson hos NSD: Ina Nepstad Tlf. Personverntjenester: 55 58 21 17 (tast 1)

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst B	Ragnhild Aursnes Dammen		14.10.2019	30335
			Deres referanse:	

Kristin Halvorsen

30335 Tverrfaglig arbeid og mestring av kronisk lungesykdom

Forskningsansvarlig: OsloMet - storbyuniversitetet

Søker: Kristin Halvorsen

Søkers beskrivelse av formål:

I helsetjenesten er det et økt fokus på tverrfaglig arbeid for å gi et mer helhetlig tilbud til pasienter og brukere. Med økt forekomst av kronisk lungesykdom, er et økt fokus på tverrfaglig samarbeid viktig for økt livskvalitet og opplevelse av å mestre utfordringene i hverdagen. Dette understrekes i både helsepolitiske føringer og forskning. Til tross for dette er det manglende kunnskap om tema.
Hensikten med studien er å undersøke helsepersonell sine erfaringer med å arbeide tverrfaglig for å oppnå mestring hos pasienter med kronisk lungesykdom når de er til rehabilitering. Videre er hensikten å undersøke hva pasienter med kronisk lungesykdom innlagt til rehabilitering opplever at bidrar til mestring i samhandling med det tverrfaglige behandlingsteamet.
Studien benytter seg av kvalitativ metode, i form av fokusgruppeintervjuer. Systematisk tekstkondensering benyttes i analysen.
Resultatene skal bidra i tverrfaglig mestringsarbeid for personer med kronisk lungesykdom.

REKs vurdering

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt, mottatt til fristen 20.08.2019. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst B) i møtet 18.09.2019. Vurderingen er gjort med hjemmel i helseforskningsloven § 10.

Etter komitéens vurdering vil ikke prosjektet, slik dets formål er beskrevet i søknad og protokoll, kunne bringe ny kunnskap om helse eller sykdom.

Hva som er medisinsk og helsefaglig forskning fremgår av helseforskningsloven § 4 bokstav a hvor medisinsk og helsefaglig forskning er definert slik: «virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom».

Det er institusjonens ansvar å sørge for at prosjektet gjennomføres på en forsvarlig måte med hensyn til for eksempel regler for taushetsplikt og personvern.

Vedtak

Avvist (utenfor mandat)

Prosjektet faller utenfor helseforskningslovens virkeområde, jf. §§ 2 og 4 bokstav a. Det kreves ikke godkjenning fra REK for å gjennomføre prosjektet.

Komitéens avgjørelse var enstemmig.

Ragnhild Emblem
Professor, dr. med.
leder REK sør-øst B

Ragnhild Aursnes Dammen
Seniorrådgiver

Kopi sendes:
OsloMet ved øverste administrative ledelse post@oslomet.no

Klageadgang

Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK sør-øst B. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst B, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag (NEM) for endelig vurdering.

RISIKO- OG SÅRBARHETSANALYSE FOR FORSKNINGSPROSJEKT VED OSLOMET

Fyll ut arkene 1) Risikovurdering og 2) Oppsummering_Prioritering.
Se på arkfanen "Veileder" for ytterligere informasjon.

Forskningsprosjekt - tittel:	TVERRFAGLIG SAMARBEID SOM ARENA FOR MESTRING HOS MENNESKER MED KRONISK SYKDOM
Prosjektleder:	Kristin Halvorsen
Prosjektnr NSD (hvis aktuelt):	121257 - vurdert som klart til oppstart 21.10.1019
Prosjektnr REK (hvis aktuelt)	30335 - vurdert som ikke meldepliktig 14.10.2019
Prosjektnr i UBW (Agresso) (hvis aktuelt):	Ikke aktuelt
Prosjektets formål (kort beskrivelse):	Formålet med studien er å få økt forståelse for hva som bidrar til mestring for pasienter med kronisk lungesykdom med et tverrfaglig behandlingsteam.
Antall registrerte informanter :	30-36
Kategorier av registrerte informanter (f.eks. studenter, medlemmer i et medlemsregister, pasienter)	pasienter og helsepersonell
Beskriv hvordan eventuelle koblingsnøkler lagres:	lagres på kryptert minnepinne i brannsikkert skap på OsloMet
Antall prosjektmedarbeidere i forskningsprosjektet?	5

Dokumentet skal lagres i arkivsystemet P360. Slik gjør du det:
1) Trykk på 360° øverst på høyre side i menylinja, etter at du har fylt ut skjemaet.
2) Logg på P360.
3) Trykk: Lagre som nytt dokument i P360. Det åpnes et vindu/sak i P360. Velg "Notat uten oppfølging".
4) Fyll ut saksnummer som gjeld ditt fakultet/sentra og tittel på dokumentet. (Se egen bruksanvisning).
5) Trykk "Fullfør".

Saksnr i P360:
HV: 18/12622
LUI: 18/10490
SAM: 18/11207
SPS: 18/11221
SVA: 18/11208
TKD: 18/09703

Nr.	Kategorier	Underkategorier	Hendelse	Beskrivelse/verdivurdering	Risikoelement	Eksisterende tiltak	Risikonivå			Nye tiltak
							S	K	Risiko	
	Vurder kun hendelser og risikoelement som er reelle og relevante for dette prosjektet. Bruk nedtrekksmeny (drop down). Du kan velge samme kategori på flere linjer.	Benytt nedtrekksmeny (drop down).	**Hva kan skje?**	**Hva er den uønskede hendelsen? Hvilke tap oppstår? Hvilken betydning for prosjektet?**	**Brudd på KIT (K = Konfidensialitet, I = Integritet, T = Tilgjengelighet).** Se på arkfanen "Veileder" for ytterligere informasjon. *Fyll ut kolonnene til høyre, om eksisterende tiltak, risikonivå og nye tiltak, basert på de risikoelementene som er aktuelle, slik det er gjort i eksempelet*	**Hva kan hindre det i å skje? Hvordan kan det oppdages?** Spesifiser allerede eksisterende tiltak.	**Sannsynlighet og konsekvens på en skala fra 1 til 4. 1 = Lav/liten, 4 = Svært høy.** Risiko generes automatisk som resultat av sannsynlighet og konsekvens.			**Beskriv forslag til nye tiltak.** De kan deles opp i organisatoriske, menneskelige og teknologiske sikringstiltak.
EKSEMPEL	***Datainnsamling***	***Lydopptak***	*Mister diktafon på vei fra informant til kontoret.*	*Uvedkommende får tilgang på opplysninger om informanter. Alle intervjudata som er lagret på diktafon mistes. Betydning for prosjektet avhenger av hvor mye informasjon som er lagret på diktafonen.*	**Konfidensialitet** *(At informasjon ikke blir kjent for uvedkommende)*	*Overføre informasjon fra diktafon til annen lagringsenhet etter hvert intervju.*	*2*	*3*	*5*	*Kryptere diktafon. Vurdere å bruke mobilapp.*
					Integritet *(At informasjon ikke blir endret utilsiktet eller av uvedkommende)*	*[Tekst]*			*0*	*[Tekst]*
					Tilgjengelighet *(At informasjon er tilgjengelig ved behov)*	*Samme som for konfidensialitet.*	*3*	*4*	*7*	*Gjøre nytt intervju*

1	**Datainnsamling**	**Intervju**	Tap/tyveri av transkripert fil (som er lagret på bærbart utstyr)	Uvedkommende kan gjenkjenne opplysninger i filen, dersom den ikke er tilstrekkelig avidentifisert.	Konfidensialitet	Det bærbare utstyret skal oppbevares trygt, skal være innelåst etter nødvendig bruk. Det vil benyttes minnebrikke som er kryptert i dikatfon. Deretter lagres lydfiler innelåst på kryptert minnepinne og ekstern harddisk. Innsamlede data skal transkriberes og avidentifiseres så raskt som mulig etter endt intervju. Lydfilene skal slettes så snart det er mulig, etter prosjektslutt.	1	1	2	[Tekst]
					Integritet	Informasjonen skal ikke endres unødvendig ved avidentifisering.	1	1	1	[Tekst]
					Tilgjengelighet	Det er kun studenten(e) og veileder(e) som skal ha tilgang til de transkriberte intervjufilene på krypterte og passordbeskyttede pc'er på OsloMet. Uvedkommende har ikke adgang til filene.	1	1	2	[Tekst]

2	**Datainnsamling**	**Lydopptak**	Koblingsnøkkelen er ikke sikret forsvarlig.	Koblingsnøkkel som avslører personidentifiserende data avsløres og fører til at informanter blir identifisert	Konfidensialitet	Lydopptak skal lagres på ekstern harddisk. Harddisken skal krypteres, og oppbevares i et separat skap, uten tilgang for uvedkommende. Lydfiler skal transkriberes umiddelbart etter intervju. Minnepinne skal oppbevares i låsbart skap, og slettes i henhold til avtale med NSD og OsloMets rutiner. Koblingsnøkkel oppbevares i annet separat skap, sammen med signerte samtykkeskjemaer på OsloMet. Samtykkeskjemaene oppbevares i lukkede konvolutter.	1	1	2	[Tekst]
					Integritet	Informasjon skal ikke endres, og skal ikke være tilgjengelig for uvedkommende.	1	1	2	[Tekst]
					Tilgjengelighet	Det er kun student og	1	1	2	[Tekst]
3	**Analyse**	**Intervjukoding**		Uønsket utlevering av personlige opplysninger	Konfidensialitet	Hver informant blir avidentifisert ved transkripsjon. Det blir derfor ikke mulig å identifisere enkeltpersoner i teksten.	1	1	2	[Tekst]
					Integritet	Informasjon vil ikke endres vesentlig. Informasjon vil ikke være tilgjengelig for uvedkommende.	0	0	0	[Tekst]
					Tilgjengelighet	Det er kun studenten(e) og veileder(e) som vil ha tilgang til informasjonen, gjennom at koblingsnøkkel oppbevares kryptert ved OsloMet separat fra all annen informasjon knyttet til prosjektet.	1	1	2	[Tekst]

4	**Analyse**	**Transkribering**		Uønsket utlevering av personlige opplysninger	Konfidensialitet	Vedkommende som har gjennomført intervjuer, og som transkriberer intervjuene, avidentifiserer informasjonen slik at data som kan føre til gjenkjennelse (eks. Navn, sted, sjelden diagnose) fjernes. Det er kun OsloMets sine egne Pcer som brukes, og disse må være frakoblet nettverk.	1	1	2	[Tekst]
					Integritet	Informasjonen vil ikke endres. Informasjonen vil ikke være tilgjengelig for uvedkommende.	0	0	0	[Tekst]
					Tilgjengelighet	Det er kun studenten(e) og veileder(e) som vil ha tilgang på informasjonen.	1	1	2	[Tekst]
5	**Analyse**	**Andre**		Uønsket utlevering av personlige opplysninger	Konfidensialitet	Ingen andre enn studentene og veilederene skal ha tilgang til de transkriberte tekstene. Alt materiale som analyserer er avidentifisert. Tekstanalysen blir gjort manuelt, evnt. ved hjelp av digitale programmer (eks, Nvivo). Tekstanalysen utføres av studentene og veileder(e).	1	1	2	[Tekst]
					Integritet	Informasjon skal ikke endres, og skal ikke være tilgjengelig for uvedkommende.	0	0	0	[Tekst]
					Tilgjengelighet	Det er kun studenten(e) og veileder(e) som vil ha tilgang på informasjonen.	1	1	2	[Tekst]

6	**Avslutning**	**Slette**		Uønsket utlevering av personlige opplysninger	Konfidensialitet	Lydfiler skal lagres på kryptert harddisk som oppbevares innelåst på OsloMet. Lydfiler transkriberes og avidentifiseres på PC uten kobling til nettverk. Ved prosjektslutt destrueres filene. Koblingsnøkkel lagres innelåst, separat fra lydfilene, og slettes umiddelbart etter at den ikke har noen verdi (etter datainnsamlingen) i tråd med NSD sine retningslinger.	1	1	2	[Tekst]
					Integritet	Informasjonen vil ikke endres. Informasjonen vil ikke være tilgjengelig for uvedkommende.	0	0	0	[Tekst]
					Tilgjengelighet	Det er kun studenten(e) og veileder(e) som vil ha tilgang på informasjonen.	1	1	2	[Tekst]
7	**Avslutning**	**Anonymisering**		Uønsket utlevering av personlige opplysninger	Konfidensialitet	I den ferdige masteroppgaven vil ikke informantene sin identitet være mulig å gjenkjenne. All presentasjon av informanter er anonymisert.	1	1	2	[Tekst]
					Integritet	Informasjon skal ikke endres, og skal ikke være tilgjengelig for uvedkommende.	0	0	0	[Tekst]
					Tilgjengelighet	Det er kun studenten(e) og veileder(e) som vil ha tilgang på informasjonen.			0	[Tekst]
	Avslutning	**Lagringskrav etter prosjektslutt**		Uønsket utlevering av personlige opplysninger	Konfidensialitet	Innhold på minnepenn/harddisk og kodenøkkel slettes etter avtalt tid med NSD. Informerte samtykkeskjemaer vil bli makulert etter prosjektslutt.	1	1	2	[Tekst]

8					Integritet	Informasjon skal ikke endres, og skal ikke være tilgjengelig for uvedkommende.	0	0	0	[Tekst]
					Tilgjengelighet	Det er kun studenten(e) og veileder(e) som vil ha tilgang på informasjonen.	1	1	2	[Tekst]
9	**Teknisk**	**Andre**		Uønsket utlevering av personlige opplysninger	Konfidensialitet	Transkriberingen av data vil skje på Pcer ikke koblet til internett. Prosjektet er godkjent i NSD, og opprettholder de sammer som er satt for beskyttelse av personvernopplysninger i dette prosjektet.	1	1	2	[Tekst]
					Integritet	Informasjon skal ikke endres, og skal ikke være tilgjengelig for uvedkommende.	0	0	0	[Tekst]
					Tilgjengelighet	Det er kun studenten(e) og veileder(e) som vil ha tilgang på informasjonen.	1	1	2	[Tekst]

Oppsummering/tiltaksplan på grunnlag av risikovurderingen:

I risikovurderingen (forrige ark), beskrev du ulike hendelser, risikonivåer og eksisterende samt nye tiltak knyttet til disse.

I denne oppsummeringen/tiltaksplanen ønsker vi at du beskriver nærmere hvordan du har prioritert de valgene du har gjort knyttet til å behandle data i prosjektet.

Skriv gjerne kort om hvilke vurderinger du har gjort for tiltakene du har valgt, og hvilke risikoreduserende tiltak som skal gjennomføres i den forbindelse.

Lydfiler blir oppbevart på ekstern hardisk. Hardisken er kryptert og blir oppbevart innelåst uten tilgang for uvedkommende. Koblingsnøkkel er kryptert og oppbevares innelåst og separat fra lydfiler på kryptert minnepinne. Sikkerhetskopi av lydfiler og koblingslister skal ligge innelåst i brannsikre separate skap ved OsloMet. Datasikring blir gjennomført i tråd med regelverk ved OsloMet. Hardisker og minnepinner med personopplysninger og lydfiler destrueres ved prosjektlutt, i tråd med NSD og REK sine godkjenninger.

Journal of Clinical Nursing Author Guidelines

1. SUBMISSION

Thank you for your interest in the *Journal of Clinical Nursing*. Note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium. See Cover letter in Section 4 **Preparing Your Submission** for further details.

Once you have prepared your submission in accordance with the Guidelines, manuscripts should be submitted online at https://mc.manuscriptcentral.com/jcnur

The submission system will prompt you to use an ORCID iD (a unique author identifier) to help distinguish your work from that of other researchers. **Click here** to find out more.

Click here for more details on how to use **ScholarOne**

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We look forward to your submission.

Data Protection

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more **here ...**

Preprint Policy

The Journal of Clinical Nursing (JCN) will consider for review articles previously available as preprints. Authors may also post the **submitted version** of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The Journal of Clinical Nursing (JCN) is an international, peer reviewed, scientific journal that seeks to promote the development and exchange of knowledge that is directly relevant to all spheres of nursing practice. The primary aim is to promote a high standard of clinically related scholarship which advances and supports the practice and discipline of nursing. The Journal also aims to promote the international exchange of ideas and experience that draws from the different cultures in which practice takes place. Further, JCN seeks to enrich insight into clinical need and the implications for nursing intervention and models of service delivery. Emphasis is placed on promoting critical debate on the art and science of nursing practice.

JCN is essential reading for anyone involved in nursing practice, whether clinicians, researchers, educators, managers, policy makers, or students. The development of clinical practice and the changing patterns of inter-professional working are also central to JCN's scope of interest. Contributions are welcomed from other health professionals on issues that have a direct impact on nursing practice.

We publish high quality papers from across the methodological spectrum that make an important and novel contribution to the field of clinical nursing (regardless of where care is provided), and which demonstrate clinical application and international relevance.

Topics include but are not limited to:

- Development of clinical research, evaluation, evidence-based practice and scientific enquiry;
- Patient and family experiences of health and health care; illness and recovery;
- Nursing research to enhance patient safety and reduce harm to patients;
- The nature of nursing need, intervention, social interaction and models of service delivery;
- Clinical nursing leadership;
- Examination of clinical decision-making;
- Exploration of organisational or systemic factors that enhance or impede the provision of effective, high-quality nursing care;
- Application and dissemination of clinical knowledge and theory;
- Role development and inter-disciplinary working, exploring the scope and changing boundaries of clinical nursing; and
- Cultural comparisons and evaluations of nursing practice in different health sectors, social and geographical settings.

Useful Resources

Nurse Author & Editor is a valuable resource for authors, editors and reviewers involved or wanting to become involved in nursing journals and the free Nurse Author & Editor newsletter contains useful articles including the Writing for Publication **booklet** which you may find helpful.

If you are presenting a paper from a study from which publications have already been drawn, or are planned, please carefully read our ***guidance pertaining to multiple publications from a single study.***

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

i. Original Articles

Pilot studies are not suitable for publication as original articles.
Word limit: 8,000 words maximum (quotations are included in the overall word count of articles, and abstract, references, tables and figures are excluded).

Abstract: 300 words maximum, no abbreviations. Structured under the sub-headings: Aims and objectives; Background (stating what is already known about this topic); Design; Methods (for both qualitative and quantitative studies state n); Results (do not report p values, confidence intervals and other statistical parameters); Conclusions (stating what this study adds to the topic); Relevance to clinical practice. Trial registration details (if required).

Main text structure: Introduction (putting the paper in context - policy, practice or research); Background (literature); Methods (design, data collection and analysis); Results; Discussion; Conclusion; Relevance to clinical practice.

References: 50 maximum; all references must be available in English
Impact Statement: should contain 2-3 bullet points under the heading 'What does this paper contribute to the wider global clinical community?'

Research Reporting Checklist: May be required. Please see **Section 5**.

ii. Review Articles

Literature reviews on any area of research relevant to clinical nursing are welcomed.
Word limit: 8,000 words maximum (quotations are included in the overall word count of articles, and abstract, references, tables and figures are excluded).

Main text structure: Review Articles should be structures, under the sub-headings: Introduction, Aims, Methods, Results, Discussion, Conclusion, and Relevance to Clinical Practice.

References: 50 maximum; all references must be available in English.

Research Reporting Checklist: Required. Please see **Section 5**.

iii. Discursive Articles

Word limit: 8,000 words maximum.
Main text structure: Aims; Background; Design (stating that it is a position paper or critical review, for example); Method (how the issues were approached); Conclusions, Relevance to clinical practice.

iv. Special Issue Articles

Authors interested in submitting a paper for a forthcoming Special Issue must contact the Editorial Office to discuss and agree submission of the paper with the designated Special Issue Guest Editor before submission to the journal takes place. Upon submission, Authors must indicate that the paper is to be considered for a Special Issue.

v. Registered Report

Journal of Clinical Nursing is now considering submissions of Registered Reports. Registered Reports are a new form of empirical article in which the methods and proposed analyses are pre-registered and reviewed prior to research being conducted. For more information please refer to our **Registered Reports guidelines**.

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Artikkel til medstudent

Interdisciplinary collaboration to increase coping for patients with COPD during pulmonary rehabilitation: healthcare professionals' experiences.

A qualitative focus group study

Journal of Clinical Nursing

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ABSTRACT

Aims and objectives: To explore healthcare professionals' experiences of working interdisciplinary to increase coping for patients with COPD during in-hospital pulmonary rehabilitation.

Background: Patients with COPD often have low levels of physical activity, low social interaction and struggle with accepting their own life situation. Pulmonary rehabilitation is proven to increase perceived quality of life and coping ability, however there is limited research regarding how and why interdisciplinary collaboration during pulmonary rehabilitation actually contribute to increase patients' coping of their illness.

Design: Qualitative design.

Methods: The data consist of qualitative focus group interviews with 14 healthcare professionals, three-six in each group. The data were analysed based on thematic analysis described by Braun et al.

Results: Six themes emerged from the data. These were: the importance of knowing each other, the patients as resources, working together to see the whole picture, providing safety, motivation and knowledge, challenges in interdisciplinary work and preparing patients to return home.

Conclusions: The results indicate that interdisciplinary collaboration is needed to be able to see the whole picture and further support patients with COPD to experience coping during pulmonary rehabilitation. However, limited time can prohibit this. Furthermore, empowering patients and preparing them for life after pulmonary rehabilitation seems to be of great value. Further research is needed to explore how healthcare professionals include patients in their treatment plan to increase patient empowerment, and how this might contribute to patients being able to maintain the positive outcomes from pulmonary rehabilitation.

Relevance to clinical practice: Leaders of healthcare professionals must be aware of how limited time might reduce the positive outcomes from interdisciplinary work. As patients often lose motivation after pulmonary rehabilitation, patients might benefit from further interventions and follow-up once at home.

Keywords: pulmonary rehabilitation, coping, chronic obstructive pulmonary disease, COPD, interdisciplinary collaboration, focus group interviews

1 INTRODUCTION

The incidence of chronic lung diseases is increasing all over the world. More specifically, Chronic Obstructive Lung Disease (COPD) is predicted to be the third leading cause of death by 2030 (World Health Organization (WHO), 2020). In Norway, over 250 000 people have been diagnosed with COPD, and there are probably many undiagnosed cases (The Norwegian Directorate of Health, 2012). COPD is characterized by persistent airflow limitation and respiratory symptoms such as dyspnoea, cough, sputum production, wheezing and chest tightness (Global Initiative for Chronic Obstructive Lung Disease (GOLD), 2020). In this article, COPD will be used as an umbrella term for different chronic lung diseases.

Pulmonary rehabilitation (PR) is a comprehensive intervention which include exercise training, health education and behaviour change. The intervention is designed to improve physical and psychological health of people living with a chronic respiratory disease, and should encourage long-term adherence to health-enhancing actions (Spruit et al., 2013). Furthermore, PR has shown to relieve dyspnoea, improve emotional function and exercise capacity, overall improve health related quality of life and improve anxiety and depression associated with COPD (Amalakuhan & Adams, 2015; McCarthy et al., 2015). The intervention should be individualized to meet the patients different needs, based on disease severity, complexity and comorbidities (Spruit et al., 2013). PR has additionally been recognized as a beneficial way to promote patient empowerment (Disler et al., 2015). Empowerment may be understood as a process to increase a patient's ability to gain control over health-related decisions and cope with everyday challenges. To achieve patient empowerment, patients need knowledge about their disease, must willingly participate in the process of care and be involved in decision making revolving their health (Palumbo, 2017).

During PR patients are met with an interdisciplinary approach (Spruit et al., 2013). In interdisciplinary collaboration, different disciplines, such as e.g. doctors, nurses, physiotherapists, social workers and occupational therapists work together to share knowledge, skills and expertise to enhance the patient care (Nancarrow et al., 2013). Working interdisciplinary is important to give a more comprehensive treatment to each patient. In line with this knowledge, there is an increased focus on healthcare services having an interdisciplinary approach. This includes working in interdisciplinary teams, and having different disciplines work closely together to support patients. In interdisciplinary work it is stated that each discipline should not know only their own role, but as well have knowledge about the other disciplines roles whom these patients may need within the healthcare system (Ministry of Education and Research, 2012).

2 BACKGROUND

Previous research has shown that people with COPD often have low levels of daily physical activity. Physical activity is often associated with exertional dyspnoea, and is therefore sometimes avoided (Robinson et al., 2018). Low physical activity can worsen the disease, with increased breathlessness and increased muscle weakness (Polkey, Moxham, & Polkey, 2006). Research show that people with COPD struggle with accepting their life situation and are less socially active (Marx et al., 2016), and are more likely to struggle with depression, anxiety and reduced quality of life (Amalakuhan & Adams, 2015; Russell et al., 2018). PR has proven to be a beneficial way to increase perceived quality of life (Robinson et al., 2018). Additionally, research show that collaborating interdisciplinary in health care contribute to patients with COPD experiencing increased quality of life and coping (Fotokian, Mohammadi Shahboulaghi, Fallahi-Khoshknab, & Pourhabib, 2017; Paap, Bode, Lenferink, Terwee, & Palen, 2015). Regardless positive outcomes from interdisciplinary PR, research show that the benefits often decline after patients return home (Robinson et al., 2018; Spruit et al., 2013; Stewart et al., 2014).

3 THEORETICAL FRAMEWORK

Experiencing coping can be an important part of increasing experienced quality of life for people with COPD (Paap et al., 2015). Coping is a broad concept and can be understood in many ways. It can be about achieving something new, or about accepting one’s own life situation more easily. These thoughts are inspired by the previous work and research of Bandura (1997). Bandura (1997) emphasizes how important it is to believe that one can accomplish something. He explains self-efficacy as beliefs in one’s ability to achieve desired effect by one’s action, and stated that unless people actually believe their actions can lead to some positive outcomes, people have little purpose to act at all.

4 AIM

Even though research demonstrate the importance of interdisciplinary collaboration in a rehabilitation setting, as it intent to lead to patients experiencing coping, there is a knowledge gap regarding how healthcare professionals experience why and how interdisciplinary collaboration in PR actually contribute to increase patients’ coping of their illness. Therefore, this study aims to explore healthcare professionals' experiences of working interdisciplinary to increase coping for patients with COPD during in-hospital pulmonary rehabilitation.

5 METHODS

5.1 Study design

This study has a qualitative approach, using focus group interviews, as the study aimed to explore and understand healthcare professionals' experiences (Brinkmann & Kvale, 2015).

5.2 Setting and sampling

The study was carried out in a Norwegian hospital that provides a four-week interdisciplinary PR program to patients with COPD. A purposive sampling strategy was used to recruit healthcare professionals to participate, in order to obtain rich descriptions of the participants' experiences. We wanted to include participants of different ages, sexes and professions, to get as rich descriptions as possible. To be included the participants had to work at the hospital and work with patients with COPD. Both genders at the age from 20-70 were included. Furthermore, all participants had to speak Norwegian. A leading physiotherapist recruited the participants. In total 14 healthcare professionals of different disciplines participated. The different disciplines were physiotherapist, occupational therapist, nutritionist, social worker, doctor, nurse and psychologist. The number of participants from each discipline is not stated due to confidentiality and anonymity. An overview of the participants age and work experience is shown in table 1.

TABLE 1 Characteristics of the 14 participants

Age	
Range	22-62 years
Mean	40,9 years
Work experience at the PR	
Range	2 months – 24 years
Mean	8,6 years

5.3 Data collection

Focus group interviews are a suitable method when the intention is to reveal experiences and different perspectives of a phenomenon. Specifically, focus groups can reveal experiences and perspectives that would not appear without interactions between participants in the group.

Interaction within a group can lead to participants sharing insight they wouldn’t have thought of alone; through agreement, disagreement, questioning, sharing and comparing among the group members (Morgan, 1997).

The focus group interviews took place at the hospital in a quiet room next to the healthcare professionals’ offices. The interviews were held at daytime after lunch, and the participants were offered some refreshments to contribute to creating a comfortable environment. Before the interviews officially started, they were informed that the intention was to gather different experiences and opinions and that there were no right or wrong answers to the questions. There was a moderator (first author) and an assistant (second author) were present in each focus group interview. The interviews were conducted in November-December 2019.

Three focus group interviews were conducted, with three-six participants in each group. The interviews were based on a semi-structured interview guide, developed to answer the research question. All authors contributed in the developing of the interview guide. Each interview lasted somewhere between 55 and 65 minutes. Interviews were audio taped and transcribed verbatim by the first author.

5.4 Data analysis

The data analysis was based on thematic analysis described by Braun, Clarke, Hayfield, and Terry (2019), which is a method for capturing patterns across qualitative datasets. The method includes six phases, were the first one is familiarization. In this step, the goal is to get to know the data. Both the first and the fourth author read all the transcripts. Whilst reading the transcripts, thoughts and notes were written down, which lead to the second phase, generating codes. To systematically make sense of the data an open thematic coding was performed, where the transcripts were organized in codes where similar quotes with similar meaning were placed under the same code. In the next phase, constructing themes, similar codes were placed under themes. Themes were created and constructed across the data and codes. During this process some codes were recoded, and some quotes were placed under different codes. The fourth phase was to review the themes, to see if the data supported the themes. Additionally, some themes were rethemed. In the fifth phase, the aim was to define and clarify the names of the themes, to make sure the themes capture the essence of the results and to make sure that readers would know what to expect when reading the themes. The final and sixth phase was to produce the report. In this phase it was important to verify that the themes worked well, both individually and together, in relation to the dataset and the research question.

5.5 Research ethics

The study was reported to the Norwegian Centre for Research Data (NSD) and the data protection officer at the hospital. The participants signed a voluntarily and free informed consent form prior to the interview.

6 RESULTS

Six themes that reflect the experiences healthcare professionals have working interdisciplinary to increase coping for patients with COPD during in-hospital PR were identified. The themes reflected on their experiences regarding what was important to be able to collaborate interdisciplinary, and how interdisciplinary collaboration could contribute to patients experiencing coping. Furthermore, some challenges in interdisciplinary collaboration were elaborated. The six themes were: the importance of knowing each other, the patients as resources, working together to see the whole picture, providing safety, motivation and knowledge, challenges in interdisciplinary work and preparing patients to return home.

6.1 The importance of knowing each other

Knowing each other and having a relation appeared as an important theme. Several participants and disciplines described that knowing each other well as a healthcare professional was an important aspect of being able to support the patients in the best possible way. Knowing each other was important in order to feel comfortable around one another, dare to ask each other questions, call each other when they needed an opinion or had something to discuss. This was expressed as stated in the quotation below in one of the focus group interviews:

> When we know each other better and are more comfortable in each other’s company, I believe we can work better together and help the patient more (Participant 6, focus group 1).

Additionally, to be able to help the patients experience increased coping, it was important to have knowledge regarding the other disciplines. The participants described the importance of knowing the other disciplines approaches and abilities to be able to know who to refer the patient to according to the needs of each patients. Knowledge about the other disciplines was described as important to know which possibilities that exist to help the patients properly, as the quotation below emphasizes:

> Because you have to know how the other disciplines work, to be able to use their knowledge properly, in the right way… and to actually pick up on things. … and then you have to know the other disciplines' field and have an understanding of the human being as a whole (Participant 1, focus group 2).

However, several participants mentioned that they wished they had more knowledge about what every discipline can offer. Some of the participants shared frustration regarding that other healthcare professionals did not know what other professions could offer to support patients, and therefore did not refer them to their discipline. Hence, some of the healthcare professionals sometimes felt neglected.

6.2 The patients as resources

The participants emphasized that in the interdisciplinary work the relation and knowledge among them as healthcare professionals were not the only important aspect. It was as important and meaningful that the patients learned to know each other. They mentioned that through lectures, group conversations and random conversations in the hallway, patients learned from each other and motivated each other. The participants additionally experienced that several patients accepted their own life situation and felt less shameful after meeting others in comparable situations with similar diseases. Knowing how much patients benefit from peer support, the healthcare professionals structured the PR so patients would interact as a part of the treatment. One participant explained how they perceived peer support:

> I think several experiences, not only coping, but accepts a bit more after being here. Seen more people in the same situation, … maybe they lose as bit of that sense of shame they can carry when alone. It makes everyday life easier to cope with, and one views everyday life at home in a different way when they have been here (Participant 1, focus group 1).

6.3 Working together to see the whole picture

Working interdisciplinary contributed to seeing the whole picture of the patients' disease and consequences of it. They explained how different disciplines picked up on different observations, which implied that every discipline is needed to contribute to patients experiencing coping. How to see the whole picture, was explained like so by one participant:

> I believe that we work in such different ways. We all have different focal areas, especially the different disciplines, which means that we pick up on many aspects of the patient's life. And I find that very important, because I believe that health and rehabilitation involve so much more than just that lung. There are so many aspects we need to acknowledge to be able to help the patient evolve or experience coping or improved quality of life. So, to me, interdisciplinary collaboration is when we are all working together. And that is so important, because we must be able to see the whole picture (Participant 1, focus group 2).

To be able to see the whole picture, communicating with each other was pointed out as a key issue. The participants expressed how important it is to talk among and across disciplines, to be able to realise what they can and cannot do to support the patients in as many aspects as possible, to make sure they pick up on things and realise how the patient is doing. Receiving others point of view and their thoughts was expressed as important, especially regarding patients that have difficulties with experiencing coping. They explained that some patients did not want to participate, and in these situations, they needed input from other disciplines to realize why and how they might support them further on. For instance, one of the participants explained how a patient seemed unmotivated, but after consulting with the psychologist, it appeared that the patient was depressed. This provided a new insight, which contributed to the process of understanding the whole picture for this particular patient. Seeing the whole picture of the patient's disease was described as such by one participant:

> To collaborate interdisciplinary, is to consult with a physiotherapist or a nurse or a psychologist about how this patient is doing in his or her everyday life, or in this case, at the rehabilitation. That often brings a lot of extra information, because the patients want to perform as well as they possibly can when they show up for their consultations. I might have an impression that the patient's level of function is much better than it actually is (Participant 4, focus group 1).

6.4 Providing safety, motivation and knowledge

An important objective in the interdisciplinary work was to empower the patients to feel safe. Both feeling safe and finding motivational factors were key for patients to dare to try new activities and push themselves. In the participants experience, patients dared to try new physical challenges or do activities they avoided at home when they felt safe amongst the healthcare professionals and fellow patients. They mentioned how this often led to patient coping and one participant explained it like this:

> And they dare to challenge themselves a bit when they are here, because they know that we are around. It is safe to try new activities and try out what … what you could not do at home. And then one experiences coping, because one can do something. Dares something, accomplishes something (Participant 1, focus group 1).

Participants stated that through lectures and conversations with different disciplines, patients learned more about their disease and improved their bodily awareness. The participants described that more knowledge about how to handle the disease, such as how to handle exacerbations or learning breathing techniques, helped the patients feel more secure in themselves. This would again lead to them feeling more equipped to try something new and experience “new” coping. Moreover, increased knowledge was described as helping the patients to understand how the PR could increase their experience of coping at home. For example, helping the patients realise how being stronger could increase their ability to master more activities of daily living (ADL) on their own, like being able to shower without help.

6.5 Challenges in interdisciplinary work

The participants described how interdisciplinary collaboration could be demanding in several ways. Firstly, it was described as time-consuming, e.g. interdisciplinary meetings, reading the other disciplines notes and locating different healthcare professionals and patients as they were located all over the hospital. The participants emphasised that the time-challenges were especially noticeably recently, as the hospital was understaffed. Some participants described how they sometimes did not have time to see their patients every day as planned. Even though interdisciplinary collaboration was identified as time-consuming, they accentuated how important it was to work interdisciplinary at the PR.

Limited time implied not having enough time to discuss every patient, and particularly all aspects of the patient’s life and health. Some participants expressed how limited time sometimes resulted in feeling somewhat unappreciated during interdisciplinary meetings, mentioning how they felt like their thoughts about the patient’s rehabilitation did not matter as much as medical aspects. Two participants expressed how this made them feel in the quote below:

> Often, or at multiple occasions unfortunately, the medical aspects are in focus. And then when you share your thoughts about the patient, it feels kind of awkward that you shared it. It gets kind of quiet after you shared it, until someone says “okey, let’s move on” (Participant 1, focus group 3).
>
> …
>
> Agreed. And I think that is because we do not always see the whole picture. And because we do not have enough time (Participant 5, focus group 3).

Another issue raised by participating healthcare professionals were concerns regarding if they really worked interdisciplinary or just worked side by side. Some mentioned that the different disciplines individually worked on assisting the patient, and not always discussed what they could do interdisciplinary to support the patient in the best possible way. Moreover, some participants felt that seeing the whole picture was challenging, due to “the lung” sometimes being too much in focus. In addition, the participants stated that it occasionally felt like it was forgotten that these lungs were inside a human being, with its own personality and mind. Further, limited time did as well challenge their ability to see the whole picture.

6.6 Preparing patients to return home

The participants described that even though patients had learned a lot about how to manage everyday life with a COPD, the healthcare professionals participating in the study meant that it often was a challenge for patients to stay motivated and not return to old habits when they returned home. They explained that several patients returned to the rehabilitation, some even multiple times. Knowing how challenging staying motivated was for patients, the healthcare professionals described having an interdisciplinary plan for returning home as crucial. Especially, already having an appointment, for example with a physiotherapist, was brought up as important to promote that patients would continue to experience coping once at home.

7 DISCUSSION

This study has explored healthcare professionals’ experiences working interdisciplinary to increase coping for patients with COPD during in-hospital PR. The findings reveal that an interdisciplinary approach was necessary to see the whole picture of the patient’s disease, and contributed to patients experiencing coping through providing safety, motivation and increasing patient’s knowledge regarding their disease. However, the findings did as well reveal that limited time could prohibit these positive outcomes gained from working interdisciplinary. Therefore, the discussion will mostly focus on the challenges regarding time limitations.

Not having enough time affected the interdisciplinary PR negatively in several ways. Firstly, the results revealed that limited time sometimes resulted in healthcare professionals not always finding time to see patients each day as planned. Limited time has in previous research appeared to affect patients negatively, as patients reported having few opportunities to ask questions, sometimes felt rushed and lacked faith in the healthcare professionals (Jackson, Oelke, Besner, & Harrison, 2012; Russell et al., 2018). Not having faith in healthcare professionals can be an obstacle in the process of patients experiencing coping. Our study found that the participants recognized safety and increased knowledge as important factors for patients to experience coping, as these factors seemed to increase patient's courage to try new activities. In relation to this, previous research found that patients start to participate once they trust their health care providers (Fotokian et al., 2017). Additionally, patients with chronic conditions have in previous research expressed gaining new information from healthcare professionals as highly valuable. However, patients expressed a need to discuss the received information with healthcare professionals to be able to fully understand it and to integrate the knowledge to their condition (Dwarswaard, Bakker, Staa, & Boeije, 2016). These findings may imply that limited time have a negative impact on patients, as it might reduce their chances of gaining more knowledge and trusting the healthcare professionals. Limited time might therefore reduce patients' chances to experience coping.

Even though having enough time was an issue, the participant all acknowledged that every discipline was needed in the process of seeing the whole picture of the patient's disease. Patients with chronic conditions often have an emotional burden, and different disciplines are therefore needed to be able to address various needs, both psychosocial and medical (Russell et al., 2018). Different disciplines must therefore communicate and collaborate, as no single healthcare professional can meet all patient needs (Martin, Ummenhofer, Manser, & Spirig, 2010; Nancarrow et al., 2013). Even though the participants all agreed on the importance of collaborating interdisciplinary, the findings showed that they were not always able to discuss every patient in an interdisciplinary way, partly because of limited time. Additionally, they expressed that they sometimes failed to see the whole picture. This corresponds to the findings of Russell et al. (2018), where the healthcare professionals did not always have time to recognise the emotional issues, and how it sometimes led to patients not coping sufficiently. This underlines how important interdisciplinary collaboration is to be able to see the whole picture and support the patients with as many aspects as possible. However, limited time can challenge healthcare professionals' ability to do so.

As limited time affected if each patient was discussed in an interdisciplinary way, some participants felt like medical and physical aspects were prioritized. Physical or medical related topics have been discussed and prioritized before social aspects in previous research (Duner, 2013). In our study, this led to other disciplines feeling like their opinion regarding patients at interdisciplinary meetings did not matter as much as the doctor or physiotherapist. This is consistent with the previous findings, where some disciplinary team members believed their participation with patient cases were not valued as much (Goldsmith, Wittenberg-Lyles, Rodriguez, & Sanchez-Reilly, 2010). A review by O'Reilly et al. (2017) report that healthcare professionals experience traditional hierarchies, where the doctors is at the top. One can argue that the medical aspect is a crucial part of treating patients with COPD and need to be prioritized. Therefore, interdisciplinary meetings where medical and physical aspects are prioritized might be both necessary and logical. However, this might act as a barrier to optimal interdisciplinary collaboration. If some disciplines feel neglected and stop sharing their input, or if there is never time to discuss other aspects of patients health than the medical and physical, the ability to see the whole picture and support the patients to experience coping might be reduced.

The participants explained when patients improved their knowledge about their disease, such as how to handle exacerbations or learned breathing techniques, patients were more secure in themselves and dared to try new activities. This corresponds with Hogg, Grant, Garrod, and Fiddler (2012) findings, as their results revealed that increased knowledge and understanding of symptoms, lead to greater control over breathlessness. PR did as well reduced anxiety and fear associated to activity, and therefore patients dared to push themselves and try new activities. In time, this lead to increased patients' self-efficacy for coping with breathlessness and being active. Robinson et al. (2018) found that managing breathing techniques was an important factor for patients with COPD to be active, especially continuing to be active after returning home, as they found that these learned skills increased patient's self-efficacy and perceived empowerment. This finding correlates with the findings in our study, as the participants described that more knowledge improved patients understanding of how the PR could contribute to experiencing coping at home.

The results revealed that not only did the interdisciplinary approach support patients to experience coping, but the participants did as well describe how meaningful it was for patients to get to know others in similar situations and how the patients supported and motivated one another. Meeting patients in similar situations can be a valuable emotional support (Dwarswaard et al., 2016). The findings in the review by Disler et al. (2015) revealed that peer support at PR lead to increased patient empowerment. Patients felt more normal and freer to engage in activities without having to hide their symptoms. Peer support was found to be a clearly more important factor for motivation than support from friends or family. In other findings, social support, both peer support and verbal support from healthcare professionals, increased patients self-efficacy during PR (Hogg et al., 2012). Bandura (1997) described social support as a component to increase perceived self-efficacy. However, loosing social support after discharge possibly could have a negative effect on patients self-efficacy and ability to maintain physical activity (Hogg et al., 2012; Robinson et al., 2018). On the other hand, Hogg et al. (2012) found that peer support could be a factor to long-term adherence to maintain self-efficacy in relation to exercise. Therefore, prioritizing patient interaction at PR could be an important factor for patients continuing coping and exercising at home. Still, it is a prevailing problem that the achieved benefits during PR often decline after returning home (Robinson et al., 2018; Spruit et al., 2013; Stewart et al., 2014).

The results revealed that the participants often experienced that patients unfortunately lost motivation and returned to old habits after the rehabilitation. Robinson et al. (2018) found that increased perceived self-efficacy and empowerment affected patient’s ability to continue being active at home. To increase patient empowerment, patient do not only need knowledge about their disease, they should as well be involved in decision making (Palumbo, 2017). However, research reveal that patients are not sufficient involved in the development of their treatment plan, and healthcare professionals do not always acknowledge that patients are experts on their own illness (Disler et al., 2015), and should be more involved in decision making (Russell et al., 2018). In order to increase patient empowerment, healthcare professionals need to develop treatment plans that addresses individual needs, as patients are different and one cannot increase patient empowerment with the same treatment plan (Halvorsen et al., 2020). Focus on increased patient empowerment could therefore be an important factor for patients to maintain achieved benefits after PR. However, the interview guide did not include specific questions regarding increasing patient empowerment, such as how involved patients were in the development of their treatment plan and how well the healthcare professionals addressed individual needs.

8 STRENGTHS AND LIMITATIONS OF THE STUDY

With a focus group study design, it was achievable to obtain deeper understanding regarding healthcare professionals' experiences of working interdisciplinary to increase coping for patients with COPD during in-hospital PR. However, focus group interviews can be challenging if sensitive topics are being discussed (Brinkmann & Kvale, 2015; Morgan, 1997), and some subjects might be easier to discuss in individual interviews than in a group setting (Morgan, 1997). This study took place in a hospital where all employees were used to talk and discuss in interdisciplinary meetings, and most of the rehabilitation was in general group based. Therefor the risk of participants not sharing in a group setting was considered limited. As discussed, focus on increased patient empowerment could be an important factor for patients to maintain achieved benefits after PR. Still, the interview guide did not include specific questions regarding increasing patient empowerment, such as how involved patients were in the development of their treatment plan. It is therefore unclear if specific questions regarding this could have provided other results and more knowledge.

As the first and fourth author read all the transcripts, a profitable discussion regarding the analysis and results were conducted. The validity was enhanced as Brinkmann and Kvale (2015) describes credibility to increase validity and the fourth author has previously written several articles within the health promotion field. Another possible limitation to consider, is that the interviews were conducted in Norwegian and translated to English. Brinkmann and Kvale (2015) explains how one needs to transform an oral language to a written language, and that this process should give the quotations a clearer meaning. In the translation, some words were therefor edited out. However, these small adjustments did not change the meaning of the quotations. Finally, this study has a relatively small sample of 14 participants. In total the participants provided enough information to get a certain point of saturation. Nevertheless, including more participants in the study could have provided even more knowledge.

9 CONCLUSION

The findings in our study indicate that healthcare professionals need to know one another and have knowledge about other disciplines to be able to collaborate interdisciplinary. Furthermore, an interdisciplinary approach is needed to be able to see the whole picture and further support patients with COPD to experience coping during PR. Interdisciplinary collaboration has proven to contribute to patients experiencing coping through providing safety, finding motivational factors and increasing patient's knowledge regarding their disease. Additionally, peer support can contribute to increase knowledge, motivation and acceptance of patient’s own life situation during PR. However, limited time might affect healthcare professional’s ability to see the whole picture and support patients to experience coping. Furthermore, preparing patients for life after PR seems to be of great value as patients often lose motivation once at home. Focus on increased empowerment seems to be of importance for patients to be able to maintain positive outcomes gained during PR. Further research is needed to explore how healthcare professionals include patients in their treatment plan to increase patient empowerment, and how this might contribute to patients being able to maintain the positive outcomes from PR.

10 RELEVANCE TO CLINICAL PRACTICE

This study demonstrates that healthcare professionals working interdisciplinary, can increase patients with COPD’s ability to experience coping during PR. Limited time can on the other hand challenge healthcare professionals ability to collaborate interdisciplinary, and thereby their ability to see the whole picture of the patients situation and support the patients to experience coping. Additionally, the study emphasizes that there is a risk of prioritizing medical aspects and thereby failing to notice the whole picture. Therefore, leaders working in healthcare services must be aware of how limited time might reduce the positive outcomes from interdisciplinary work. Awareness might enable healthcare professional’s ability to adjust to these challenges. As patients often lose motivation after PR, patients might benefit from further interventions and follow-up once at home. Such as digital follow-up or motivational sessions. Further research is needed to determine if this might enhance long-term benefits of PR.

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REFLEKSJONSOPPGAVE

Erfaringer knyttet til utføring av fokusgruppeintervjuer

av

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INNHOLDSFORTEGNELSE

1.0 INTRODUKSJON OG BAKGRUNN

Denne refleksjonsoppgaven er en del av et felles masterprosjekt, hvor vi er to studenter som har samarbeidet gjennom hele masterprosessen. Vi har skrevet hver vår artikkel individuelt, men denne refleksjonsoppgaven er felles for oss begge. Refleksjonsoppgaven gir mulighet for refleksjon rundt et eller flere temaer som vi ikke fikk utdypet i artiklene. Masterprosjektet vårt har som mål å se nærmere på erfaringer knyttet til opplevelse av mestring for mennesker med kronisk lungesykdom innlagt til tverrfaglig rehabilitering. Vi har sett på temaet fra ulike perspektiver. Den ene studenten har hatt fokus på helsepersonell sitt perspektiv, mens den andre studenten har sett på temaet fra pasientenes perspektiv. Vi har levert en felles prosjektbeskrivelse i forkant av masterprosjektet, og vi har begge vært med på samtlige fokusgruppeintervjuer. Studenten som skriver om helsepersonell sitt perspektiv var moderator i fokusgruppeintervjuene for helsepersonell, mens den andre studenten var sekretær. Motsatt var det i fokusgruppeintervjuene for pasientene. Gjennom hele prosessen har vi delvis hatt individuell veiledning, og delvis felles veiledning. Veiledningen var individuell ved oppstart høst 2019, og frem til starten på analyseprosessen. Når vi nærmet oss slutten av analysen i januar 2020, startet vi med felles veiledning. Dette erfarte vi som positivt for oss begge, da felles veiledning bidro til å få en økende forståelse for tematikken kronisk lungesykdom og mestring.

Kvalitativ metode kan belyse ulike menneskelige erfaringer (Malterud, 2017). Hovedfokuset i våre studier er å få en dypere forståelse av hva pasienter som lever med kronisk lungesykdom, og hvordan helsepersonell som jobber med denne pasientgruppen, opplever at bidrar til økt mestring for pasientene som er innlagt på et tverrfaglig rehabiliteringstilbud. Kvalitativ metode kan, ifølge Malterud (2017), bidra til å gi en dypere forståelse av hvorfor mennesker opplever, og gjør ting på ulike måter. Derfor ble kvalitativ metode sett på som hensiktsmessig å benytte seg av i våre studier. Å utføre kvalitative fokusgruppeintervjuer var nytt for oss begge ved prosjektets start. Dette førte til at både forberedelsene og selve gjennomføringen av fokusgruppeintervjuene var en krevende og lærerik prosess. Vi opplevde det til tider som utfordrende å gjennomføre fokusgruppeintervjuer, og vi ble i større grad bevisst at det er mange ulike faktorer som er av betydning når det kommer til å innhente et godt datamateriale via denne metoden.

1.1 Hensikt med refleksjonsoppgaven og problemstilling

Hensikten med denne refleksjonsoppgaven er å reflektere rundt de erfaringene vi har med oss fra prosessen med å benytte oss av fokusgruppeintervju som metode. Vi ønsker å rette søkelyset mot utføringen av fokusgruppeintervjuene med hovedvekt på rollen som moderator, samt reflektere over hvordan gruppedynamikken kan ha påvirket datamaterialet vårt. Som en del av denne oppgaven ønsker vi også å reflektere over at vi var to studenter som samarbeidet gjennom hele masterprosjektet. På grunnlag av dette blir problemstillingen som følger;

”Gjennomføring av fokusgruppeintervjuer og studentsamarbeid i egen masterstudie”

1.2 Oppgavens oppbygning

Videre i denne oppgaven vil vi presentere litteratur og forskning vi anser som relevant for vår oppgave. Vi vil deretter reflektere rundt problemstillingen i lys av relevant litteratur og forskning, og knytte det opp mot våre egne erfaringer. Avslutningsvis blir oppgaven oppsummert.

2.0 METODE

Vi har jobbet metodisk med å finne relevant litteratur og forskning, samt benyttet oss av pensum vi har blitt kjent med gjennom masterstudiet. Vi ønsker å sette våre egne refleksjoner opp mot den relevante litteraturen og forskningen vi har funnet, for å besvare vår problemstilling. Videre i dette kapittelet vil vi redegjøre for hvordan vi har funnet den aktuelle litteraturen og forskningen.

2.1 Litteratursøk

Vi har gjort systematiske søk i PubMed, samt søk i databasen Oria og tidsskriftet Journal of Qualitative Health Research, for å finne relevant litteratur og forskning som vi ønsker å benytte oss av videre i refleksjonsoppgaven. Mange ulike artikler er blitt gjennomgått under denne prosessen. Vi har valgt en variert tilgang på litteratur og forskning for å best mulig kunne svare på vår problemstilling. Artiklene vi har valgt å bruke videre i oppgaven ble valgt etter å ha lest titler og sammendrag. Dersom noen av artiklene virket relevante, ble hele artikkelen nøye gjennomgått.

Fire av artiklene vi har benyttet oss av er forskningsartikler, mens den femte er en teoretisk fagfellevurdert vitenskapelig artikkel skrevet av en av de mest sentrale forfatterne innen fokusgruppeintervju, David Morgen.

De fem inkluderte artiklene er:

Tittel	**Forfatter og årstall**
Interaction between participants in focus groups with older patients and general practitioners	Janne Moen, Karolina Antonov, Lars G. Nilsson & Lena Ring, 2010
Methodological aspects of focus groups in health research: Results of qualitative interviews with focus group moderators	Anja P. Tausch & Natalja Menold, 2016
Metodologiske og praktiske utfordringer ved bruk av fokusgrupper som forskningsmetode - med fokus på pårørende som informanter	Trude Fløystad Eines & Ingela Thylen, 2012

Analysing group interaction in focus group research: Impact on content and the role of the moderator	Mette Grønkjær, Tine Curtis, Charlotte de Crespigny & Charlotte Delmar, 2011
Why things (sometimes) go wrong in focus groups	David Morgan, 1995

I tillegg til forskning, er også relevant litteratur vi har blitt kjent med gjennom masterstudiet vårt blitt benyttet. Vi har hovedsakelig benyttet oss av følgende:

Tittel	**Forfatter og årstall**
Focus groups as qualitative research	David Morgan, 1997
Kvalitative forskningsmetoder for medisin og helsefag	Kirsti Malterud, 2017
En introduksjon til samfunnsvitenskapelig metode	Asbjørn Johannessen, Per Arne Tufte & Line Christoffersen, 2016
Empowerment i helse- og sosialfaglig arbeid: Floskel, styringsverktøy eller frigjøringsstrategi?	Ole Petter Askheim, 2012
Det kvalitative forskningsintervju	Steinar Kvale & Svend Brinkmann, 2017

3.0 TEORETISK PERSPEKTIV

Dette kapittelet presenterer litteratur og forskning som ble beskrevet under metodekapittelet. Vi har hovedsakelig tatt utgangspunkt i litteratur skrevet av sosiologen David Morgan, som ofte blir omtalt som en pioner innen metoden fokusgruppeintervju. Vi anser Morgan sitt arbeid som et viktig bidrag inn i vår teoretiske forståelse av fokusgruppeintervju som metode. Morgan sin litteratur har vært svært nyttig og lærerik for oss, spesielt når det kommer til vår forståelse av oss selv som uerfarne i moderatorrollen. Annen litteratur vi har benyttet knyttet til fokusgruppeintervjuer henviser også ofte videre til Morgan, eksempelvis i Malterud (2017).

3.1 Fokusgruppeintervjuer

Fokusgruppeintervjuer er, ifølge Morgan (1997), hovedsakelig gruppeintervjuer hvor det er flere informanter samlet som diskuterer et gitt tema. Formålet ved fokusgruppeintervjuer er å få frem ulike synspunkter og perspektiver på temaet som tas opp i gruppen. Det er ikke et formål i fokusgruppen at man skal komme frem til en enighet om spørsmålene som diskuteres, men det er ønskelig å få frem forskjellige synspunkter på saken via en ikke-styrende intervjustil (Kvale & Brinkmann, 2017). Morgan (1997) skriver at en av fordelene med et fokusgruppeintervju er selve samspillet mellom deltagerne i gruppen. Det faktum at deltagerne kan ha en diskusjon seg imellom, samt kommentere hverandres tanker og opplevelser, danner gode muligheter for å få et godt og rikelig datamateriale.

Et fokusgruppeintervju ledes av en moderator, i tillegg til en sekretær (Malterud, 2017). Moderatoren skal organisere intervjuet, og styre diskusjonen i gruppen til en viss grad (Johannessen, Christoffersen, & Tufte, 2016). Moderatoren skal også forsøke å skape et trygt miljø, hvor deltagerne kan komme med personlige og ulike synspunkter (Morgan, 1997). Før et fokusgruppeintervju gjennomføres, skal det i likhet med andre intervjuer opprettes en intervjuguide. Morgan (1995) omtaler viktigheten av å utføre pilotintervjuer for å få testet at intervjuguiden bidrar til at man får innhentet aktuell og ønsket datamateriale. Ved å utføre pilotintervjuer kan intervjuguiden justeres, eksempelvis ved å undersøke hvilke spørsmål som fører til gode diskusjoner i gruppen, samt at man får et tidsperspektiv på gjennomføringen av fokusgruppeintervjuene.

3.2 Gruppedynamikk

Gruppedynamikken spiller en sentral rolle for hvilke data man får ut av fokusgruppeintervjuet (Morgan, 1997). For noen deltagere kan det oppleves enklere å dele og delta i en diskusjon i en gruppe. Å høre at andre forteller om sine erfaringer kan oppmuntre til at man også deler egne erfaringer. På denne måten fører samspillet i en gruppe til gode og meningsfulle data (Johannessen et al., 2016; Morgan, 1997). På en annen side kan noen deltagere være svært aktive, noe som kan føre til at det blir mindre plass til deltagere som kanskje ikke er like delaktige i diskusjonen. Som moderator er man avhengig av at deltagerne i gruppen er delaktige for å klare å få til gode og relevante diskusjoner. Dette krever visse ferdigheter av moderatoren, da det blir moderatorens oppgave å klare og få i gang en diskusjon, samt sørge for at relevante og interessante temaer diskuteres. Under noen fokusgruppeintervjuer kan det oppstå et livlig samspill i gruppen, som til tider kan oppleves som noe kaotisk. Dette er også en faktor moderatoren må forholde seg til (Morgan, 1997). Både samhandlingen og deltakelsen i en fokusgruppe vil naturlig påvirkes av både ledelse og struktur (Tveiten, 2016). Det blir derfor vesentlig at moderatoren er bevisst sin egen rolle, og er forberedt på at man til tider må være mer aktiv i styringen av gruppen, mens man andre ganger bør være litt mer tilbaketrukken.

3.3 Maktbalanse

Når vi skal reflektere over gruppedynamikk, ser vi det som hensiktsmessig og naturlig å trekke inn begrepet makt. Det finnes mange ulike utsagn og teorier om makt, og dette er et begrep man bør være bevisst innenfor helse-og sosialfag. Ifølge Askheim (2012) er makt noe som befinner seg overalt, og er tilstede ved alle sosiale relasjoner. At makt ofte kan bli assosiert med en negativ betydning, eksempelvis maktmisbruk, er noe som er gjentagende i teorien (Askheim, 2012; Tveiten, 2016). I lys av gruppedynamikk kan maktasymmetrien oppstå på forskjellige måter, eksempelvis mellom moderatoren og forskningsdeltakerne (Kvale & Brinkmann, 2017). Makten trenger ikke nødvendigvis være bevisst utøvd, og det er ikke alltid at man selv føler at man representerer makt (Tveiten, 2016).

4.0 REFLEKSJON

I dette kapittelet vil vi reflektere over egne erfaringer med å gjennomføre fokusgruppeintervjuer og studentsamarbeidet i egen masterstudie, i lys av anvendt teori og forskning.

4.1 Utforming og bruk av intervjuguide

Sammen med veileder og medveileder utformet vi to ulike intervjuguider i forkant av fokusgruppeintervjuene. Vi utformet en til fokusgruppeintervjuene med helsepersonell, og en annen til gruppene med pasientene. Intervjuguiden bør inneholde spørsmål som inviterer deltagerne til å reflektere godt over temaene man spør om (Thagaard, 2013). Det første fokusgruppeintervjuet som ble gjennomført, var med pasientgruppen. På dette fokusgruppeintervjuet var medveileder også med. Medveileder hadde ingen aktiv rolle under selve utførelsen av fokusgruppeintervjuet, men var med og reflekterte sammen med oss i etterkant. Medveileder kom med innspill til hvordan vi kunne forbedre intervjuguiden ytterligere. Vi endte opp med å endre noe på intervjuguiden etter hvert fokusgruppeintervju, både for pasientgruppen, og i gruppene med helsepersonell. Dette gjorde vi på grunnlag av erfaringer vi fikk med oss fra de første fokusgruppeintervjuene i begge gruppene, da vi innså at vi hadde skrevet ned noen lukkende spørsmål i intervjuguiden som ikke førte til utdypende refleksjon. Videre innså vi at vi også hadde noen spørsmål som resulterte i gjentagende svar fra deltagerne. Vi merket at justering av intervjuguiden underveis førte til bedre flyt i intervjuene og mindre gjentagende spørsmål, samt mer utfyllende svar fra deltagerne.

Da vi erfarte at intervjuguiden ble bedre utarbeidet etter erfaringer fra fokusgruppeintervjuene, innså vi at det kunne vært svært gunstig og hatt et eller flere pilotintervjuer i forkant. Et pilotintervju kan føre til en intervjuguide som legger mer opp til diskusjon, noe som kan føre til et rikere datamateriale (Morgan, 1995). Dersom vi hadde utført et eller flere pilotintervjuer kunne dette bidratt til at både intervjueguiden var bedre utarbeidet, og at vi mestret moderatorrollen bedre ved selve datainnsamlingen. Å mestre moderatorrollen er svært viktig i fokusgruppeintervjuer, da positive reaksjoner fra moderator kan være avgjørende under intervjuet for den videre dialogen (Thagaard, 2013). Morgan (1997) forklarer at en god gruppediskusjon krever både gode intervjuspørsmål og gode ferdigheter som moderator. Hadde vi utført et pilotintervju, ville dette muligens ført til en bedre utarbeidet intervjuguide, samt at det kunne bidratt til at vi hadde vært mer forberedt til rollen som moderator.

4.2 Gruppetilhørighet og gruppedynamikk mellom deltagerne

Fokusgruppeintervju ble som nevnt tidligere valgt som metode, da vi ønsket å få frem forskjellige synspunkter og erfaringer om tematikken. Denne metoden ble også valgt med tanke på hvordan lungerehabiliteringen var strukturert. Både pasienter og helsepersonell var vant til å jobbe og snakke i grupper, og i samhandling med ledelsen på rehabiliteringen vurderte vi derfor denne metoden som spesielt gunstig. Alle pasientene hadde en kronisk lungesykdom, og alt helsepersonell jobbet på lungeavdelingen. På denne måten hadde alle deltagerne en felles tilhørighet. Å ha en gruppetilhørighet, hvor deltagere har lignende erfaringer og en felles tilknytting til temaet, kan bidra til å danne et godt utgangpunkt for en åpen interaksjon i fokusgruppeintervjuer (Eines & Thylèn, 2012; Moen, Antonov, Nilsson, & Ring, 2010). En positiv interaksjon i en gruppe kan bidra til at både erfaringer og ulike holdninger kommer frem under diskusjonen (Eines & Thylèn, 2012). Dette kan ha hatt en positiv påvirkning på både gruppedynamikken og datainnsamlingen. Vi merket underveis i fokusgruppeintervjuene med både pasienter og helsepersonell at når en deltager kom med et innspill, spilte ofte andre deltagere videre på utsagnet og kom med sine meninger og tanker. Dette bidro dermed til at samtalen hadde god flyt, noe som videre kan ha påvirket datamaterialet vårt og ført til et rikere innhold. Vi opplevde at det hjalp deltagere å finne støtte i at andre hadde lignende erfaringer, noe som førte til at deltagerne dermed delte sine synspunkter ytterligere.

Gruppedynamikken kan også bli påvirket av dominerende deltagere (Morgan, 1997), både positivt og negativt. En deltager som er positiv dominerende, kan bidra til å oppmuntre og få mer stille deltagere til å dele mer (Moen et al., 2010). Dette opplevde vi selv i et intervju med helsepersonell, der en mer dominerende deltager ved flere tilfeller gjennom fokusgruppeintervjuet fikk en mer stille deltager til å reflektere ytterligere, og dele sine tanker med de andre i gruppen. Dette gjorde vedkommende ved å stille direkte oppfølgingsspørsmål til deltageren. Sett fra en annen side kan dominerende deltagere påvirke gruppedynamikken negativt, da dette kan føre til at andre deltagere ikke tør å ta ordet, og dermed trekker seg tilbake (Eines & Thylèn, 2012; Grønkjær, Curtis, Crespigny, & Delmar, 2011; Moen et al., 2010). I et av fokusgruppeintervjuene med pasientgruppen var det en deltager som stadig tok ordet med å svare negativt på spørsmål, var stadig uenig i andre deltagere sine opplevelser og delte generelt kun sine negative erfaringer. Dette kan muligens ha påvirket hvorvidt andre deltagere turte å dele sine eventuelt motstridende tanker. På denne måten erfarte vi hvordan dominerende deltagere kan prege gruppedynamikken på ulikt vis, og har fått økt forståelse for hvorfor det er viktig å være bevisst dette ved utføringen av fokusgruppeintervjuer.

4.3 Maktrelasjoner i gruppen

Det er flere relevante faktorer man kan se på når det kommer til moderatorens mulige innflytelse på gruppedynamikken. Som nevnt tidligere, er makt et begrep vi tenker det er sentralt å reflektere rundt. Makt kan være både positivt og negativt, og det handler om hvordan makten arter seg i praksis (Kvale & Brinkmann, 2017). En faktor som kan prege gruppedynamikken er følelsen av maktasymmetri mellom moderator og deltagerne (Grønkjær et al., 2011; Tausch & Menold, 2016). Opplevd maktasymmetri kan påvirke hva slags datamateriale man får innhentet (Jerpseth & Halvorsen, 2019). I et fokusgruppeintervju kan maktasymmetri ha innvirkning på datamaterialet ved at deltagerne kan føle at de må gi moderatoren god respons og riktige svar, og kan derfor velge å si det de tror moderatoren ønsker å høre (Moen et al., 2010). I fokusgruppeintervjuene våre med pasientgruppen kan dette ha vært et tilfelle, da det kom frem mot slutten i et av fokusgruppeintervjuene at deltagerne trodde vi var ansatt på rehabiliteringen. Her kan vi stille oss spørsmål om vi ubevisst formidlet dette budskapet, på grunnlag av at vi introduserte oss selv som våre yrkesprofesjoner ved starten av hvert fokusgruppeintervju. Kanskje har dette ført til at deltagerne svarte positivt på flere av spørsmålene. Til tross for dette har vi lagt merke til at det også kom frem negative aspekter underveis i fokusgruppene med pasientene. Dette kan vise seg å være et tegn på at ikke alle ønsket å komme med svar de følte var mer ”riktig”, og at de derfor ikke ble påvirket av måten vi introduserte oss selv på.

Sett fra et annet perspektiv kan det være at deltagerne hadde fått følelsen av at vi jobbet der, fordi de ikke var godt nok informert om hensikten med studien og studiens innhold før deltagelse i fokusgruppeintervjuet. Hvorvidt deltagere er informert om studiens formål, kan påvirke om deres forventninger samsvarer med hensikten med fokusgruppene (Malterud, 2017). Det kan være at vi burde ha forsikret oss enda bedre om at deltagerne hadde forståelse for hensikt og innhold i studien før oppstart. At noen deltagere trodde vi jobbet på rehabiliteringen kan også ses på som et forskningsetisk aspekt, da dette muligens kan ha påvirket deltagere til å delta grunnet engstelse for uheldige konsekvenser hvis de valgte å ikke delta. Alle fokusgruppeintervjuene ble startet ved at vi introduserte oss selv, våre profesjoner, vårt masterstudie og hensikt med studien, samt at pasientene fikk utdelt et samtykkeskjema fra medveileder i god tid før fokusgruppeintervjuet. Allikevel kan det vise seg at vi ikke klarte å informere om ovennevnte i tilstrekkelig grad.

Vi har i etterkant av fokusgruppeintervjuene blitt mer oppmerksomme på at i fokusgruppene med helsepersonell var deltagerne ofte mer frittalende. En følelse av maktasymmetri kan arte seg på flere måter (Askheim, 2012). Kanskje var det slik at følelsen her var motsatt, og at det var vi som følte på maktasymmetri ved at vi snakket med mennesker som var ansatt på rehabiliteringen, og som hadde god erfaring innen temaet? Vi har lagt merke til at vi ofte lot helsepersonellet snakke om ulike emner relativt lenge uten at vi stoppet dem, eller prøvde å ta ordet. Kanskje førte dette til at vi ikke klarte å lede gruppen best mulig, ved at vi ofte lot de snakke lenge om temaer som nødvendigvis ikke var helt relevante i forhold til spørsmålene i vår intervjuguide. Som Tveiten (2016) nevner, er det ikke nødvendigvis alltid at man selv føler at man representerer makt. I dette tilfelle er det ikke sikkert at helsepersonellet bevisst utøvde makt, men det kan være at vi allikevel satt med denne følelsen i oss, allerede før fokusgruppeintervjuet startet. Dette trenger ikke nødvendigvis kun å relateres til makt, men kan også ha oppstått på grunnlag av at vi er to studenter som ikke har mye erfaring med fokusgruppeintervjuer fra tidligere. Mer erfaring kan føre til at man i større grad tør å ta ordet og kontroll over diskusjonen i et fokusgruppeintervju (Morgan, 1995). Vi har gjennom denne prosessen erfart at maktbalanse naturlig vil oppstå under et fokusgruppeintervju, og at dette kan vise seg å ha hatt påvirkning på datamaterialet vi har fått. Det finnes også andre faktorer vi kunne valgt å reflektere over knyttet til maktrelasjoner i gruppen, eksempelvis gruppedynamikken deltagerne imellom, men grunnet begrensninger med tanke på oppgavens omfang velger vi å ikke gå nærmere inn på dette.

4.4 Betydningen av tidspunkt

Et annet aspekt som kan ha påvirket gruppedynamikken og datainnsamlingen er tidspunktet for når fokusgruppene ble gjennomført. At datainnsamling foregår på gunstige tidspunkter for deltagere, kan påvirke hvor villige de er til å delta (Tausch & Menold, 2016). Fokusgruppeintervjuene med helsepersonell ble holdt etter lunsj i arbeidstiden, mens fokusgruppeintervjuene med pasientene forgikk etter at deltagerne hadde spist middag. Vi erfarte selv at valgt tidspunkt affiserte intervjusituasjonen. I fokusgruppene med helsepersonell var det noen deltagere som stadig så på klokken, mens andre spurte flere ganger om hvor lenge det var igjen av intervjuet. Det ble også spurt om hvor mange spørsmål som var igjen, og ved et tilfelle ble det påpekt av en deltager at ”*vi måtte komme oss videre*”. Det var tydelig at flere deltagere hadde andre avtaler og planer de skulle videre til etter fokusgruppeintervjuet. Det kan tenkes at dette negativt påvirket dynamikken i gruppen, da man merket at flere av deltagerne hadde fokus på å avslutte intervjuet. Dette kan muligens ha hindret at noen av de andre deltagere valgte å dele ytterligere tanker og erfaringer.

Under gjennomføringen av fokusgruppeintervjuene med pasientene fremkom det av flere av deltagere at de var veldig mette og trøtte etter middag, samt slitne etter en lang dag på rehabiliteringen. Det var også en deltager som sovnet underveis i et fokusgruppeintervju. Muligens var deltagerne noe ukonsentrerte under intervjuet på grunnlag av ovennevnte, noe som kan ha ført til at de eventuelt var mindre delaktige og motiverte enn de muligens hadde vært dersom de var fullt uthvilt. Det må påpekes at vi har full forståelse for at noen av deltagerne var slitne, da de hadde et tettpakket program på rehabiliteringen, samt at de hadde ulike helseutfordringer som kan ha innvirkning på delaktighet. Allikevel var det ikke mulig å få til fokusgruppeintervjuer på andre tidspunkter, og derfor ble alle intervjuer med helsepersonell og pasienter gjennomført på disse tidspunktene.

4.5 Usikkerhet i moderatorrollen

Som moderator er det flere ulike aspekter det er nødvendig å tenke på under gjennomføringen av et fokusgruppeintervju. Det er blant annet viktig at man som moderator klarer å skille mellom når man skal ta en mer passiv rolle og la diskusjonen i gruppen flyte, og når det er gunstig å endre retning på diskusjonen (Grønkjær et al., 2011; Morgan, 1996). Tausch og Menold (2016) erfarte i sin studie at diskusjonen i deres gjennomførte fokusgruppeintervjuer ofte kunne gå i en uønsket retning, og at moderatoren ikke mestret å få deltagerne tilbake til det aktuelle temaet. Dette er noe vi også erfarte, da det var flere tilfeller under fokusgruppeintervjuene hvor deltagerne snakket om andre temaer enn det aktuelle, og i et av intervjuene ble det påpekt av en deltager at han syntes at *”samtalen måtte styres mer inn mot spørsmålet igjen”*. Vi har reflektert over det faktum at mer erfaring som moderator kunne bidratt til at vi hadde klart å ta styring over intervjusituasjonen i høyere grad, noe som igjen kunne ført til et rikere datamateriale.

Gjennom alle fokusgruppeintervjuene opplevde vi at vi mestret godt å holde oss til tildelte roller som enten moderator eller sekretær. Vi hadde avtalt på forhånd at det hovedsakelig var moderatoren som skulle lede fokusgruppeintervjuet, men at sekretæren også kunne stille oppfølgingsspørsmål underveis. I dette tilfellet merket vi godt utbytte av å være to til stede i intervjusituasjonen. Da ingen av oss hadde erfaring med å være moderator fra tidligere, merket vi begge at vi var litt nervøse før vi selv skulle være moderator i aktuelle fokusgrupper. Vi erfarte at å ha en intervjuguide var positivt for oss i dette tilfellet, da vi hadde noe konkret å forholde oss til. På den andre siden merket vi at det var lett å bli opphengt i de forberedte spørsmålene som sto nedskrevet. En intervjuguide kan føre til at man fokuserer mye på det man ønsker svar på, noe som kan føre til at man glemmer hva som er av interesse for deltagerne (Morgan, 1995; Tausch & Menold, 2016). At vi til tider var noe opphengt i intervjuguiden førte også til at noen spørsmål ble stilt til tross for at deltagerne allerede hadde snakket om temaet, samt at det var noe utfordrende å stille oppfølgingsspørsmål til det som ble sagt. Morgan (1997) skriver at en moderator må kunne hoppe over temaer som allerede har vært snakket om, samt stille oppfølgingsspørsmål til nye temaer som kan fremkomme under fokusgruppeintervjuet. Vi opplevde at når vi var sekretærer, så var det enklere å lytte til hva deltagerne sa, noe som igjen førte til at det var lettere å stille gode oppfølgingsspørsmål. Dette kan relateres til at vi trolig var mindre nervøse i sekretærrollen, og det ble derfor lettere å følge opp temaene og utsagn fra deltagerne.

I etterkant av transkripsjonene har vi innsett at vi begge synes det var utfordrende å stille oppfølgingsspørsmål ved tilfeller av stillhet under fokusgruppeintervjuene. Stillheten ble ofte benyttet av oss som en mulighet til å gå videre til neste spørsmål i intervjuguiden. Vi har i ettertid reflektert over at dersom vi hadde utnyttet de stundene hvor det ble stille under fokusgruppeintervjuene til å stille oppfølgingsspørsmål, kunne dette bidratt til at vi hadde fått mer utdypende svar fra deltagerne. I tillegg er det som moderator viktig å klare og la det være noe stillhet under et intervju, da stillhet i intervjusituasjoner kan føre til at deltagere kommer med ytterligere tanker og synspunkter (Bengtsson & Fynbo, 2018; Kvale & Brinkmann, 2017). Likevel opplevde vi noe forbedring på evnen til å stille oppfølgingsspørsmål, samt tåle å la det være noe stillhet i gruppen, da vi fikk mer og mer erfaring i moderatorrollen for hvert gjennomførte fokusgruppeintervju.

4.6 Erfaringer knyttet til studentsamarbeidet

Gjennom første studieår på masterutdanningen Empowerment og helsefremmende arbeid oppdaget vi at vi begge to var interessert i temaet mestring og kronisk sykdom. Vi besluttet derfor at vi skulle inngå et samarbeid om masteroppgaven i april 2019. Vi utarbeidet en felles prosjektbeskrivelse, og ble allerede under denne tiden oppmerksomme på at det opplevdes positivt å være to stykker i samhandling, i en ellers ukjent prosess. Vi har samarbeidet gjennom hele prosessen, fra prosjektbeskrivelse til ferdig skrevet artikkel. Som nevnt innledningsvis, hadde vi individuelle veiledningstimer i starten, men begynte med felles veiledningstimer da vi nærmet oss avslutningsfasen på analyseprosessen. I denne perioden innså vi at det var gunstig å ha hverandre til stede under veiledningene, for å komme med innspill og tilbakemeldinger, samt at det bidro til at artiklene hadde en sammenheng. Likevel var det til tider utfordrende å sette seg tilstrekkelig inn i den andre medstudenten sin artikkel for å kunne gi konstruktive tilbakemeldinger, da vi opplevde at hodet var fullt av tanker knyttet til utformingen av våre egne individuelle artikler.

I tiden hvor vi gjennomførte fokusgruppeintervjuene opplevde vi det som både positivt og trygt å ha hverandre som støtte. Vi hadde på forhånd avtalt at studenten som skulle skrive om temaet fra helsepersonell sitt perspektiv var moderator i fokusgruppeintervjuene med helsepersonell, og omvendt i fokusgruppeintervjuene med pasientene. Det var også blitt avtalt at det var moderatoren som hovedsakelig skulle lede fokusgruppeintervjuene, men at sekretæren skulle ta ordet og hjelpe til dersom moderatøren frøs til, eller diskusjonen i gruppen stagnerte. Dette bidro til en noe tryggere følelse i starten av en ellers ukjent rolle som moderator i et fokusgruppeintervju.

I etterkant av fokusgruppeintervjuene, ser vi at vi kunne ha brukt mer tid på å reflektere sammen rundt intervjusituasjonen vi nylig befant oss i. Malterud (2017) skriver at når fokusgruppeintervjuene er gjennomført, kan moderatoren og sekretæren oppsummere og reflektere over viktige hovedpunkter angående samhandlingen i gruppen mens lydopptakeren fortsatt er slått på. Dette ble også vektlagt i artikkelen skrevet av Moen et al. (2010), hvor forskerne i etterkant av hvert fokusgruppeintervju hadde en diskusjon hvor de reflekterte over ulike aspekter i gruppedynamikken, blant annet knyttet til om det var noen deltagere som utpreget seg som eksempelvis mer dominerende enn andre. Dersom vi i større grad hadde tatt oss tid til å reflektere over både gruppedynamikken og oss selv i moderatorrollen i etterkant, kunne det ha bidratt positivt på flere måter. Eksempelvis kunne det ha bidratt til at vi var mer forberedte til gjennomføring av neste fokusgruppeintervju, ved at vi i større grad hadde reflektert over hvordan vi bedre kunne håndtert stillhet i gruppen, muligheten for å stille oppfølgingsspørsmål samt refleksjon knyttet til løsrivelse fra intervjuguiden. Hadde vi benyttet oss av erfaringene våre i høyere grad kunne dette muligens ha bidratt til at vi følte oss mer selvsikre i rollen som moderator.

Studentsamarbeidet vi har hatt gjennom hele denne prosessen har definitivt bidratt til mange nye erfaringer. Vi har oppnådd en mye bredere og rikere forståelse om tematikken opplevelse av mestring for mennesker med kronisk lungesykdom innlagt til tverrfaglig rehabilitering, enn vi hadde fått dersom vi hadde ufført hele prosessen individuelt. Gjennom et tett samarbeid har vi lært mye om både pasientenes og helsepersonell sine erfaringer knyttet til oppgavens tematikk.

5.0 STYRKER OG SVAKHETER VED REFLEKSJONSOPPGAVEN

En styrke ved denne refleksjonsoppgaven er at vi hovedsakelig har fokusert på tre temaer, rollen som moderator og gruppedynamikk, samt det faktum at vi var to studenter som samarbeidet gjennom hele vår masterprosess. Det positive med å avgrense refleksjonen til ovennevnte er at vi grundig har fått reflektert over valgte temaer. På den andre siden kan det være negativt at det er andre ting av betydning i vårt masterprosjekt som vi ikke har fått reflektert ytterligere over. Vi har begrenset oss til å ta med litteratur og forskning vi opplevde som relevant for å besvare vår problemstilling. Vi kan ikke utelukke at det ikke finnes annen relevant litteratur og forskning som vi kunne ha benyttet oss av i oppgaven, for å belyse problemstillingen ytterligere.

6.0 AVSLUTNING

I denne oppgaven har vi reflektert over gjennomføringen av fokusgruppeintervjuene med hovedvekt på rollen som moderator, samt gruppedynamikk. I tillegg har vi reflektert over at vi var to studenter som samarbeidet gjennom hele masterprosjektet. Vi har erfart at det er flere utfordringer man kan møte på i rollen som moderator, og at det kreves erfaring og refleksjon for å bli tryggere i denne rollen. Videre har vi blitt bevisst at gruppedynamikk i stor grad kan påvirke datamaterialet man får. Å være to studenter som samarbeidet har bidratt positivt når det kommer til opplevelse av trygghet i utførelsen av fokusgruppeintervjuene. Det har føltes godt å kunne ha en medstudent å samarbeide med gjennom hele masterprosessen, selv om det til tider var noe krevende å komme med konstruktive tilbakemeldinger til hverandres oppgaver, på grunnlag av et stort fokus på egen oppgave. Vi har opplevd at vi har fått utviklet vår forskningskompetanse, men vi er allikevel blitt bevisst at det alltid er nye og ulike utfordringer man kan møte på i denne prosessen.

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