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Research Paper

Is it my turn to speak? An analysis of the dialogue in the family-physician intensive care unit conference

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ABSTRACT

Objective: Apply turn analysis to family conferences in the pediatric intensive care unit.

Methods: We analyzed 39 audio-recorded family conferences using the Roter Interaction Analysis System. A turn was defined as a continuous block of uninterrupted statements by a speaker.

Results: Opening turns by the healthcare team (HCT) averaged 207 s, compared to 28 s for families. Turn density (number of statements/turn) was 6 for the HCT versus 2 for families ($p < 0.0001$). An average of 21 turns (26%) occurred between HCT members, resulting in substantial sections of dialogue excluding the family. Average HCT dialogue reflected a literacy demand of a 9th grade level, whereas family dialogue averaged a 5th grade level ($p < 0.0001$). More HCT turns were related to higher reading level demand ($r = 0.34$; $p = 0.03$) and lower levels of patient-centeredness ($r = -0.35$, $p = 0.03$).

Conclusion: The healthcare team can improve the communication experience for families by encouraging and facilitating family engagement in conference dialogue.

Practice implications: Changing how the healthcare team engages with families during communication events is vital to improving the experience for families. Our data suggests simple adjustments, such as limiting medical jargon and inter-team turns may lead to increased family participation and more family-centered care.

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1. Introduction

Communication is essential for family-centered care in the pediatric intensive care unit (PICU) [1–6] and an important opportunity for communication is the family conference [7–10]. The main goal of the family conference is creating a collaborative, shared dialogue [11] in which families and the healthcare team (HCT) express views and ultimately share in decision-making. We know from the literature that physicians often dominate these conversations [12–15], contributing up to 79% of the verbal content. We also know that the more actively engaged families are during the conference, the more satisfied they are with the communication [16].

Merriam Webster's dictionary defines dialogue as an exchange of ideas or opinions on a particular issue by two parties [17]. Is the

ICU family conference a true dialogue or does it function more like a carefully orchestrated dance in which there is a leader and a follower, a natural rhythm with repetition and some variation, but a recognizable flow? The literature on turn taking behaviors may give some clues to analyze this interaction.

Turn taking was first described in the sociology literature as the manner in which orderly conversation normally takes place [18]. Sequence and turn design have been described by Heritage and Maynard [19] as the bedrock elements of conversational analysis and related qualitative traditions to address issues of power, knowledge and authority, solidarity and distance, and understanding and misunderstanding [19–21]. Within the medical context, studies of sequence have most often focused on specific content (i.e., diagnosis, bad news, symptom description, treatment negotiation) or function (i.e., interruption, questions, alliance building, and emotional support). Dialogue sequence has also been studied outside of qualitative traditions by using quantitative or qualitative-quantitative hybrid designs to explore antecedents and responses to particular verbal events like patient expressions of concern and clinician responses to these expressions [22–24].

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Taking a different analytic approach from conversational and discourse analysis, Roter and colleagues examined speaker turns in terms of dialogue structure, such as turn frequency, interactivity, density, duration, and pacing, as well as broad language correlates of turn taking associated with information processing challenges experienced by individuals with restricted literacy. This approach was first used in a preliminary test of a conceptual framework of oral literacy demand in simulated genetic counseling sessions, and found that high turn density and low interactivity (number of turns per minute) were related in a systematic way to standard indicators of literacy demand such as general language complexity, Flesch-Kincaid reading level, and use of passive voice [25]. Additional analysis showed study subjects with restricted literacy (below 8th grade level) assigned to watch videos of the genetic counseling sessions learned more from sessions characterized by greater dialogue interactivity and less dense, shorter counselor turns. Interestingly, learning was not related to the more traditional measures of reading grade level, passive voice, use of genetics jargon or general language complexity, suggesting that interactivity was a more sensitive indicator of oral literacy demand at least within the genetic counseling context [26].

A second exploration extended this type of analysis to primary care physicians' performance with simulated patients [27]. More frequent, briefer turns were related to positive simulated patient ratings of affective demeanor, interpersonal satisfaction and collaborative decision-making; furthermore, turn interactivity was associated with a patient-centeredness score derived from the simulated patient visit communication coded with the Roter Interaction Analysis System (RIAS).

In prior analysis of family conferences by our group, we described 39 conference conversations in terms of session length and the verbal balance between families and the healthcare team. We found that the conferences averaged 45 min in length and were dominated by the medical team, who contributed 73% of the dialogue, of which the majority was medically-focused content. Moreover, we found a positive relationship between RIAS-based measure of patient-centeredness, which balances psychosocial and biomedically-focused talk, and parental satisfaction with the conference [15]. The current study extends our earlier analysis of these 39 family conferences in a number of important ways. First, turn analysis was applied within the context of family conferences with the goal of exploring the nature of turn exchange among multiple speakers representing the health care team and the patient's family. Second, turn analysis was designed to determine the relationships between the turn structures, oral literacy demand features (i.e., the Flesch-Kincaid grade equivalent reading level and Flesch reading ease score based on analysis of family conference transcripts), and patient-centeredness of family conference communication coded with the RIAS.

2. Methods

2.1. Study design and setting

We conducted a single-center, prospective cross-sectional study examining the dialogue between clinicians on the HCT and family members during the PICU family conference. Our unit is a 44-bed mixed medical-surgical PICU of an urban, tertiary medical center in the United States. In our PICU, family conferences are convened at the discretion of the PICU attending or at the request from family members.

2.2. Study procedure and data collection

From April 2012 to August 2014 English-speaking parents of children in the PICU making a treatment decision, defined as a

decision to initiate, escalate or withdraw medical interventions, for their child were eligible for enrollment. The PICU attending physician on service was approached daily by a study team member to determine if he/she anticipated conducting a family conference. Written informed consent was obtained from all participants in the family conference. This study was approved by our Institutional Review Board.

We collected demographic and clinical data of the patients from the medical record. Family demographic data were collected using a family survey administered immediately after the family conference. Conference data included the length and purpose of the conference and participants (including the number of participants and the clinical discipline). Participants were coded as family members or HCT members. The HCT was further classified as clinicians and non-clinicians. For the purpose of this study, we only analyzed dialogue between clinicians and family members. In this study, "HCT" is defined as the clinicians on the healthcare team. Family conferences were audio-recorded and transcribed.

2.3. Construction of turn variables

The RIAS [28] was used to characterize the HCT and family dialogue and the construction of the turn variables. The RIAS is a widely used quantitative coding tool for assessment of medical communication with high levels of coding reliability and predictive validity [29,30]. The RIAS unitizes speech as the smallest statement to which a meaningful code can be assigned, generally a complete thought (herein referred to as a statement) expressed by each speaker throughout a recorded medical visit. In this study, the RIAS was used to analyze the verbal contribution of all participants in a PICU family conference.

A turn was defined as a continuous block of uninterrupted statements by a single speaker. Back channels, statements suggesting active listening such as "hmmm", "yes" or "I see," that do not result in a floor change are not considered turns [26]. We compared number of turns, length of turns, and turn density (defined as number of statements/turn excluding back channels) between the HCT and families. We also quantified the number of intra-group turns (i.e., speech turns between 2 HCT members or 2 family members) as compared to inter-group turns (i.e., speech turns between HCT members and family members). Lastly, we analyzed the length of the opening statement made by the HCT and family members. The opening statement was defined as the first statement made by either a HCT member or family member excluding introductions. We collected data on which participant spoke first and the length of the response.

2.4. Oral literacy burden

Oral literacy burden was assessed through language complexity and readability of family conference transcripts using the Microsoft Word "grammar summary statistics". These statistics include percentage of passive sentences within the transcript and the Flesch Reading Ease Score, both indicators of plain-language, and the Flesch-Kincaid Reading Grade Level Score used to estimate the educational grade equivalent necessary to read and understand a piece of text [31]. A Reading Ease score of 60–70 is considered indicative of "plain English" and a Reading Grade Level below 6th grade is considered most appropriate for communication with the general public [32]. As in earlier work, the application of these statistics to medical dialogue has been shown to reflect a distinct dimension of oral literacy burden [25]. The grammar statistics were used on the family and healthcare team sections independently.

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