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Research paper

Audiologist–patient communication profiles in hearing rehabilitation appointments

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ABSTRACT

Objective: To profile the communication between audiologists and patients in initial appointments on a biomedical-psychosocial continuum; and explore the associations between these profiles and 1) characteristics of the appointment and 2) patients' decisions to pursue hearing aids.

Methods: Sixty-three initial hearing assessment appointments were filmed and audiologist–patient communication was coded using the Roter Interaction Analysis System. A hierarchical cluster analysis was conducted to profile audiologist–patient communication, after which regression modelling and Chi-squared analyses were conducted.

Results: Two distinct audiologist–patient communication profiles were identified during both the history taking phase (46 = biopsychosocial profile, 15 = psychosocial profile) and diagnosis and management planning phase (45 = expanded biomedical profile, 11 = narrowly biomedical profile). Longer appointments were significantly more likely to be associated with an expanded biomedical interaction during the diagnosis and management planning phase. No significant associations were found between audiologist–patient communication profile and patients' decisions to pursue hearing aids.

Conclusion: Initial audiology consultations appear to remain clinician-centred. Three quarters of appointments began with a biopsychosocial interaction; however, 80% ended with an expanded biomedical interaction.

Practice implications: Findings suggest that audiologists could consider modifying their communication in initial appointments to more holistically address the needs of patients.

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1. Introduction

Patient-centred care is documented in policy guidelines internationally as best-practice in health care [1–4]. Given that effective patient–clinician communication is at the heart of patient-centred care [5–10], its implementation may be challenging for clinicians who work with adults who have a hearing loss because of the impact of hearing loss on communication [11,12]. Therefore, it is important that audiologists and other clinicians who have patients with hearing loss work around these communication difficulties to engage their patients in health care consultations, to facilitate better treatment adherence, improved self-management, and better patient outcomes [8,13–15].

In the audiological context, treatment adherence, in the form of hearing aid uptake, remains low. For example, in a population-based study conducted in Australia, hearing aid uptake among adults with hearing loss over the age of 50 was reported to be 33% [16]. A number of patient-related factors (e.g., self-perceived hearing difficulties, positive attitude towards hearing aids, support from significant others to pursue hearing aid fitting) have been found to be associated with hearing aid uptake [17–19]. However, it may be that the interaction between the patient and audiologist also influences hearing aid uptake, as has been reported in qualitative research in hearing rehabilitation [20,21], and this is the focus of the study described here.

Indeed, recent research reveals that, despite audiologists reporting a preference for patient-centred care [22], audiologist–patient interactions remain clinician-centred and continue to have a biomedical, rather than a psychosocial focus [23–25]. Grenness and colleagues [24,25] examined the communication between audiologists and patients during initial hearing assessment appointments to ascertain to what extent audiological

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consultations were patient-centred. Using the Roter Interaction Analysis System (RIAS) [26], Grenness et al. [24,25] were able to code utterances as biomedical (i.e., referring to the medical condition or therapeutic regime) or psychosocial (i.e., referring to psychosocial concerns or lifestyle information); biomedical utterances are typically more prevalent during clinician-centred interactions, whereas psychosocial utterances are typically more prevalent during patient-centred interactions. The results revealed that slightly more than half (58%) of the questions asked by audiologists during the history taking phase were biomedical in nature, and accordingly, 51% of the information provided by patients during this phase pertained to biomedical issues such as duration of hearing loss, ear health, or history with hearing aids [25]. During the diagnosis and management planning phase wherein treatment options are typically discussed, there was a notable imbalance between biomedical and psychosocial talk [24]. More than 80% of audiologist talk devoted to education and counselling focused on biomedical topics; specifically, the types and features of hearing aids rather than discussing solutions in the context of patients' lifestyles. Patients, on the other hand, prioritised psychosocial information over biomedical information (62% vs 38%, respectively) [17].

While the aforementioned findings were novel, it is important to recognise the limitations of group statistics analysis. That is, Grenness et al. [24,25] reported a high degree of variability in the number of biomedical and psychosocial utterances produced by audiologists and patients. For example, during the diagnosis and management planning phases of appointments, audiologists contributed 32.9 utterances pertaining to psychosocial information, but this ranged from zero utterances to 145 utterances depending on the consultation [24]. Therefore, it is likely that some of the audiology consultations were more patient-centred than others. Certainly, in other areas of health care, interactions between clinicians and their patients have been found to be on a continuum from narrowly biomedical (i.e., focus of talk on

biomedical information) to psychosocial (i.e., focus of talk on psychosocial topics) and consumerist (i.e., physician answers questions of the patient) [14]. No research to date has investigated the impact of the type of audiologist–patient communication interaction on patients' decisions to obtain hearing aids.

Accordingly, the aims of this study were to extend Grenness et al.'s [24,25] research by: profiling the audiologist–patient communication interactions on a continuum from narrowly biomedical to psychosocial; and subsequently, exploring the associations between these interaction profiles and 1) characteristics of the appointment (e.g., clinician gender, patient gender, duration of appointment) and 2) patients' decisions to pursue a hearing aid fitting. Given that audiologist and patient talk has been found to differ according to the phase of the appointment [24,25], we conducted separate analyses for the history taking and diagnosis and management planning phases.

2. Method

2.1. Participants and procedure

Audiologists were invited to participate in the study via professional networking events, professional contacts, and advertisements supported by the Australian professional body for audiologists. Adult patients of participating audiologists were subsequently recruited by the audiologist when their appointment was scheduled or when they attended their appointment. The final participant sample included 26 audiologists (M = 10, F = 16) and 63 adult patients (M = 36, F = 27). Demographic information about each participant group is described in Table 1 and has been described previously in related studies (e.g., [24,25]).

Hearing assessment appointments were filmed with no researcher present, using the video application on an Apple iPod touch or iPhone 4 attached to a mini tripod. Information about each participant's degree of hearing loss, as well as their rehabilitation

Table 1
Characteristics of participants and consultations.

	Total Sample	Decision to Obtain a HA	
	(N = 63)	Yes (n = 30)	No (n = 19)
††Audiologist			
Gender			
Male–n (%)	10 (38%)	6 (32%)	6 (43%)
Female–n (%)	16 (62%)	13 (68%)	8 (57%)
Years of experience–M (SD)	11.4 (10.1)	10.7 (10.1)	11.8 (9.9)
Clients			
Age in years–M (SD)	71.6 (8.9)	74.2 (9.7)	69.6 (7.2)
Gender			
Male–n (%)	36 (57%)	20 (67%)	11 (58%)
Female–n (%)	27 (43%)	10 (33%)	8 (42%)
Degree of hearing loss			
Normal–n (%)	1 (2%)	0	1 (5%)
Mild–n (%)	21 (33%)	4 (13%)	4 (21%)
Mild-moderate–n (%)	28 (44%)	18 (60%)	10 (53%)
Moderate-severe–n (%)	12 (19%)	7 (23%)	4 (21%)
Severe-profound–n (%)	1 (2%)	1 (3%)	0
Eligible for subsidised hearing aids			
Yes–n (%)	30 (48%)	16 (53%)	9 (47%)
No–n (%)	33 (52%)	14 (47%)	10 (53%)
Appointment			
Audiologist-patient gender concordance			
Family member present			
Yes–n (%)	37 (59%)	14 (47%)	13 (68%)
No–n (%)	17 (27%)	10 (33%)	6 (32%)
Duration – M (SD)	46 (73%)	20 (67%)	13 (68%)
	57.4 (20.3)	67.2 (19.3)	55.3 (18.1)

Note: †14 patients were not recommended a hearing aid; ††total number of audiologist participants was 26. HA = hearing aid.

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