Patient Education and Counseling xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Applying a deliberation model to the analysis of consultations in haemophilia: Implications for doctor-patient communication

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ARTICLE INFO

Article history:
Received 29 June 2016
Received in revised form 23 November 2016
Accepted 27 November 2016

Keywords:
Chronic care
Deliberation dialogue
Shared decision making
Communication
Patient-Centeredness
Behavior change
Hemophilia

ABSTRACT

Objective: Literature highlights the importance of communication in order to achieve patient's adherence. However, the specific dialogical components likely to favor patient adherence are not clear. In this study, the deliberation dialogue model was applied as an ideal model of optimal deliberation to real physician-patient consultations in the field of hemophilia in order to identify misalignments with the model and possible improvements in physician-patient communication.
Methods: By applying the deliberation model, we analyzed a corpus of 30 check-up consultations in hemophilia.
Results: Of 30 consultations, 24 (80%) contained 43 deliberation dialogues. Twenty-two (51%) deliberation dialogues were complete (e.g., included an opening stage with a clear statement of the problem, an argumentation stage in which both physician and patient participated, and a closing stage with an explicit patient commitment), whereas 21 (49%) deliberations were incomplete. These featured: Lack of/partial argumentation stage; Lack of closing stage; Lack of/partial argumentation stage and lack of closing stage.
Conclusions: The deliberation model can be applied to empirical data and allows to identify causes for suboptimal realizations of deliberation.
Practice implications: Once a problem is acknowledged, attention could be paid to engage hemophilic patients in the argumentation stages and elicit their explicit commitment.

1. Introduction

In the last 30 years, an extensive body of research advocated the need for a shift from the biomedical model of medicine to the biopsychosocial model, which includes the exploration of the patient's illness experience and shared-decision making as pivotal tasks [1,2].

Within the context of chronic care, the aim of finding common ground regarding disease treatment and management is particularly relevant. If in acute care settings some decisions are mainly driven by clinical evidence and patient compliance is not always required, in chronic care it is not possible to implement an effective treatment without taking into account the patient's interpretations, feelings, preferences, values, and social context [3]. Finding common ground has been associated with better recovery from patients' discomfort and concern, better emotional health, and fewer diagnostic tests and referrals [4]. Studies across several chronic settings suggest that patients who are more communicatively involved in their consultations, who express their concerns and who interact with more patient-centered and informative clinicians experience better outcomes [5]. Although a participatory communicative style has been identified as a pivotal component to achieve adherence [6], it remains unclear what specific aspects of clinician-patient communication are more likely to favor patient adherence.

In order to answer this question, in this contribution we draw on insights from studies developed in the field of argumentation theory concerning the dialogical structure of deliberations[7]. The theoretical premises, the aims and the stages of deliberation dialogues seem to be useful conceptual constructs for the analysis of clinician-patient interactions where health objectives have to be decided and treatment choices have to be made [8,9].

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http://dx.doi.org/10.1016/j.pec.2016.11.021
0738-3991/

Deliberation dialogues are described as abstract models of deliberation that outline the most effective dialogical moves aimed at finding an acceptable course of action to achieve a certain goal [10,11]. The theoretical premise for a deliberation dialogue to happen is that there is not a compelling objective truth for following a certain course of action, therefore parties have to discuss their reasons in order to reach a collective goal which can be different from the individuals' personal goals. This is particularly relevant in the care of chronic patients, where the principle of patient autonomy has partially given back to patients the decisional power regarding their own health and treatment decisions [12].

Deliberation dialogues usually develop in three stages: opening, argumentation and closing stage (Fig. 1). Stages' names do not necessarily refer to the timeline of the consultation, but rather to the dialogical phase of the deliberative process.

In this paper we apply the theoretical model of deliberation dialogue to real doctor-patient consultations in the field of hemophilia. Hemophilia is a rare inherited bleeding disorder that requires patients to be compliant with a burdensome life-long treatment in order to maintain a good quality of life and prevent life-threatening complications. Hemophilia is caused by a deficiency of either clotting factor VIII (hemophilia A) or IX (hemophilia B). The cornerstone of hemophilia treatment is replacement therapy of the missing protein, which is given intravenously by bolus injections of clotting factor concentrates. Patients on prophylaxis regimen usually self-inject replacement therapy regularly, twice or three times a week, to prevent bleeds. Patients adopting on-demand regimen usually treat themselves only when a bleed occurs[13]. Check-up consultations are usually scheduled once a year and are aimed at discussing treatment adherence and health problems in general. As hemophilic patients are likely to suffer from other comorbidities, in these visits it is also common for physicians to discuss treatment options for joint disease, chronic hepatitis and/or HIV infection. For these reasons hemophilia care offers an interesting context for the analysis of deliberation dialogues.

In this study, by adopting a top-down approach, we applied the model of deliberation dialogue to the analysis of check-up consultations with hemophilic patients in order to identify misalignments with the model and possible improvements of physician-patient communication.

2. Methods

2.1. The hemophilia project

The video-recordings of check-up consultations used in this study were collected within a larger project on hemophilic patients' adherence [14]. The primary aim of the project was to collect videos of consultations in order to understand the communicative factors that promote adherence.

Participants in the project were physicians and patients of 2 hospital-based Hemophilia Treatment Centers in Milan and Naples.

Physicians had not received any specific communication skills training before the study. Patients were recruited during their annual check-up at the centers in the periods of January–April 2013 and January 2014. Patients over the age of 12, suffering from hemophilia A and treated on-demand or on prophylaxis were eligible to participate. The socio-demographic characteristics of physicians and patients who participated in the project are reported in Table 2. The research project was approved by the Ethical Review Boards of the participating hospitals.

2.2. Analysis of the video-recordings

The consultations collected during the project were watched by two researchers (GL, SB) to select those that contained deliberations. The consultations containing deliberations were transcribed verbatim removing all the personal identifiers. The transcripts were analyzed using the deliberation dialogue model [15] as a coding scheme. The criteria for the identification of the stages of the deliberation are described in Table 1.

Since deliberation dialogues are initiated because there is a problem that needs to be solved, during a visit there could be more than one deliberative dialogue. As a unit of analysis to define a deliberation dialogue, we considered all the exchanges related to the problem discussed. For example, if a deliberation dialogue was initiated regarding dietary habits, all the exchanges related to that problem during the conversation were considered as part of the same deliberation. Given that medical consultations are face-to-face interactions and are not rigidly structured [16], deliberative phases can develop in different moments of the consultation: a problem may be brought up, then dropped, then taken up again

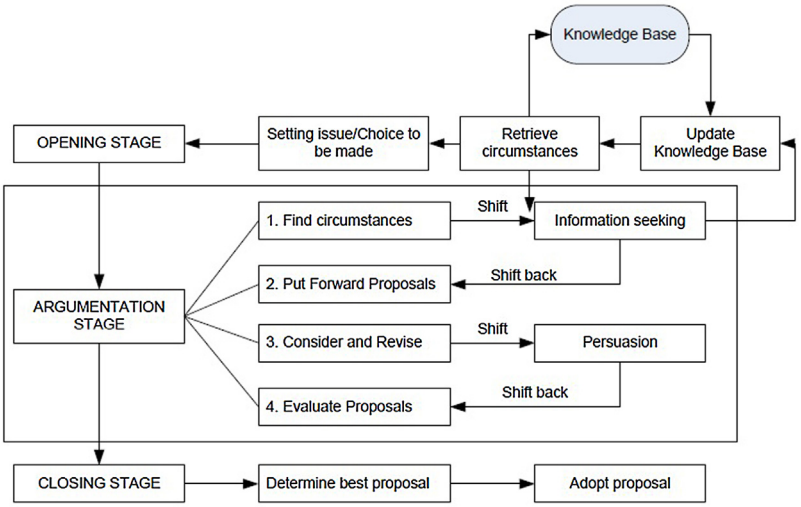

Fig. 1. The structure of deliberation dialogues (Walton, Toniolo and Norman 2014).

Please cite this article in press as: G. Lamiani, et al., Applying a deliberation model to the analysis of consultations in haemophilia: Implications for doctor-patient communication, Patient Educ Couns (2016), http://dx.doi.org/10.1016/j.pec.2016.11.021