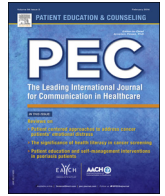




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Communication Study

Exploring the relationships between participatory decision-making, visit duration, and general practitioners' provision of argumentation to support their medical advice: Results from a content analysis

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ABSTRACT

Objective: General practitioners' medical recommendations are not always accepted by their patients. As patients bring their own beliefs, knowledge, and preferences to the medical encounter, their opinions concerning diagnosis and treatment may deviate from their doctors'. Aiming to convince their patients of the acceptability of their advice, doctors can advance arguments.

Few quantitative studies have been conducted focusing on general practitioners' provision of argumentation and little is known about the relationship between the use of argumentation and characteristics of the medical visit, such as (participatory) decision-making and visit duration. This study seeks to explore these relationships.

Methods: An observational study of seventy, randomly drawn videos of general practice consultations was conducted. A theory-based codebook was developed. Two independent coders analyzed doctors' provision of argumentation, their decision-making style, and the duration of each visit.

Results: General practitioners' provision of argumentation was found to be associated with lengthier visits and a more participatory decision-making style. In addition, visit duration and participatory decision-making appeared associated.

Conclusion: These results suggest that the use of argumentation may contribute toward achieving patient-centered care through communication.

Practice implications: As a result, the findings underscore the potential relevance of developing courses focusing on doctors' argumentation skills.

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1. Introduction

General practitioners typically offer their patients medical advice or an opinion concerning a health issue they have been experiencing. The advice may concern, for instance, the diagnosis of the health condition or the recommended treatment plan. In advising their patients, doctors provide an expert opinion that is based on medical knowledge and experience, as well as their professional preferences and beliefs. As such, doctors' recommendations can be defined as medical standpoints. Drawing on their personal experiences, values, and knowledge, patients too bring a unique perspective to the medical encounter – a perspective that is

of crucial importance for a shared treatment decision-making procedure [1–3]. Tucket [4], consequently, refers to the medical consultation as a 'meeting between experts'.

As a result of their different perspectives, patients may not always immediately accept their doctors' medical advice. Patients may have doubts about the recommendations and sometimes their opinions concerning diagnosis and treatment may contradict their doctors'. In these cases, from an argumentation theoretical point-of-view, doctor and patient can be said to have a disagreement, or a difference of opinion [5]. In order to convince their patients of the acceptability of their medical advice, doctors can advance argumentation, a collection of arguments to support their medical standpoint. By stimulating their – competent, adult – patients to engage in a reasonable discussion procedure in which the opinions of both parties are carefully weighed on the basis of their arguments, doctors can elicit their patients' viewpoints and, subsequently, try to resolve their potential disagreement.

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So far relatively little attention has been given to the role of argumentation and its characteristics in medical consultation [6]. This is perhaps not surprising, as in English the term *argument* carries the negative connotation of a fight or a quarrel – a connotation that does not seem to befit the patient-centered that has been advocated over the past decades [1–3]. In recent years, however, several authors have advocated the use of insights from argumentation theory in the study of doctor–patient interaction [6–11]. Based on predominantly qualitative case studies, they propose to conceptualize the treatment decision-making procedure in medical consultation as a rational discussion process in which doctor and patient ultimately aim to reach a mutually shared decision [7,8,12]. They argue that doctors' provision of argumentation can contribute importantly to the delivery of evidence-based and patient-centered care and, moreover, can be instrumental in achieving consultation outcomes such as patients' advice acceptance, adherence, and satisfaction [7,13].

This study seeks to contribute to the study of argumentation in doctor–patient consultation, by adopting a quantitative approach. As existing coding instruments to guide observational analyses of doctor–patient interaction, such as Roter's Interaction Analysis System (RIAS) and Bales' Interaction Process Analysis [14,15], do not include theory-driven measures to analyze argumentative discourse in particular, an inherent goal of the overall study was to develop such a measurement tool. The study design and coding procedures are addressed in Section 2. A more elaborate overview of the development and reliability of the codebook and coding sheet can be found elsewhere [13]. Using the codebook, the aim was to explore the associations between doctors' provision of argumentative support for their treatment recommendations and two distinct features of the medical encounter: visit duration and participatory decision-making style.

Previous studies have suggested that doctors' decision-making style becomes increasingly participatory with lengthier office visits [16,17]. Kaplan et al. argue that successfully involving patients in the treatment decision-making process may require time to accomplish. In the present study, building on these findings as well as qualitative studies on medical argumentation (see Labrie and Schulz [7]), it is hypothesized that (1) general practitioners' provision of argumentation in support of a medical advice is correlated with a participatory decision-making style. In addition, it is assumed that (2) earlier research findings pertaining to the association between general practitioners' decision-making style and visit duration will be confirmed. Following these assumptions, it is also hypothesized that (3) general practitioners' provision of argumentation is related to the overall duration of the visit, in such a way that the use of argumentation is associated with longer consultations.

2. Methods

2.1. Sample and design

An observational content analysis of seventy videotaped general practice consultations was conducted. Videos were randomly drawn from a database containing 808 representative general practice consultations. The videos were recorded with an unmanned camera as part of a project on doctor–patient communication carried out by the Netherlands Institute for Health Services Research in 2007–2008. General practitioners and patients provided informed consent prior to participation. The project and database have been described in more detail elsewhere [18–20].

Consultation videos of 34 general practitioners were included in the study. The majority of the general practitioners were male (61.8%). On average, 2.09 patients were included per general

practitioner (range 1–4, SD = 1.04), implying a hierarchical data structure. For 38.2% of general practitioners, only one consultation was selected and analyzed in the present study; for 29.4% of the general practitioners, two consultations were included; for 20.5% of the general practitioners three consultations were included; and for the remaining 11.7% of the general practitioners four consultations were analyzed. Due to the method of data collection, the patients (52.9% male, 47.1% female) were often not visible in the video (35.7%).

2.2. Procedures and measurements

To measure the characteristics of doctors' provision of argumentation during general practice consultation, a coding guide was developed.¹ Two female analysts coded several characteristics of the medical encounter, including participant demographics, visit duration, and a series of argumentative features of the interaction. While one of the coders was aware of the study hypotheses, the other coder was not. Both coders had received training in argumentation theory. Prior to data collection, coders trained with the coding tools, using a separate set of videos. In a pilot study, reliability statistics were computed to assess the accuracy of the coding procedures. Variables and coding categories were revised until an acceptable reliability criterion was reached.² Upon completion of the data collection, the inter-rater reliability was re-established for each of the variables under study. Overall reliable results were achieved. A detailed description of the development of the codebook and coding sheet, as well the reliability statistics, can be found in Labrie and Schulz [13].

Visit duration: For each consultation, coders were asked to note the length of the medical encounter, rounding to the nearest half-minute. Moreover, they coded the participants' gender.

Decision-making style: General practitioners' decision-making style was measured using the validated OPTION-scale, which was developed by Elwyn et al. [21] to measure the extent to which doctors involve their patients in the treatment decision-making process. Coders scored all items on a five-point scale ranging from 0 ("behavior is not observed") to 4 ("behavior observed and executed to a high standard"). A total OPTION-score was calculated ranging between 0 and 100, where 0 indicated 'least involvement' and 100 pointed to 'most involvement'.

Medical advice/standpoint: Analyzing the argumentative features of the interaction, in each consultation the coders first identified the different medical standpoints advanced by the doctor. Starting from the pragma-dialectical theory of argumentation [5], a standpoint was conceptualized as a point of view on the part of the doctor – often voiced in terms of an advice or recommendation – pertaining to, for instance, the patient's diagnosis, prognosis, treatment, or prevention plan. For each of these types of advice, a separate code was provided. The codebook contained examples of medical standpoints as well as indicator words and phrases that idiomatically signal the advancement of a standpoint (i.e., *I believe that, in my opinion, I advise you to, my recommendation is, etc.*) [13,22].

Provision of argumentation: Subsequently, coders reconstructed the arguments supporting each standpoint. An argument was defined as an utterance put forward by the doctor in an attempt to justify or refute a proposition expressed in a medical standpoint [4]. Again, signal words and phrases indicating the use

¹ The codebook and coding scheme (in English) are available upon request.

² To establish the coding reliability, Krippendorff's alpha, Cohen's kappa, and the percentage agreement were calculated for each of the variables. To determine the reliability of the OPTION-coding, exceptionally and following the original authors of the scale, an intra-class coefficient was computed. A reliability criterion of α , κ , or ICC > .80 was used.

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