

Framing the clinical encounter for greater understanding, empathy, and success

By Tine Tjørnhøj-Thomsen

As hearing care professionals know from experience, patient consultations are by nature highly subjective and thus open to interpretation. A patient's complaints may have a long and twisted history that must be summarized in a few words and deciphered by the healthcare professional.

At the recently concluded Ida Institute series, "The Process of Defining Hearing," Tine Tjørnhøj-Thomsen, PhD, associate professor in the Department of Anthropology at Copenhagen University and the author of this article, shared insights from the field of medical anthropology on "framing"

the consultation between healthcare professional and patient, an interaction she dubs the "clinical encounter."

Drawing upon findings from the medical arena and her experience as an anthropologist, Dr. Tjørnhøj-Thomsen provides insight to help hearing care professionals re-examine the way they practice today and strengthen their ability to build positive relationships with their patients. The theoretical model she proposes here contributes to understanding the wider context in which professionals operate and to finding a holistic approach to treatment.

There are many similarities in the challenges faced by medical doctors and hearing care professionals. Chief among them is maintaining a focus on the patient and the patient's unique world. Physicians have found medical anthropology very useful in fostering a more humanistic approach to clinical practice and thus encouraging a more patient-centered interaction that can lead to greater understanding, empathy, and patient satisfaction.

The discipline of medical anthropology has been described as a study of cultural beliefs and behaviors that are associated with the recognition, acceptance, and management of health and illness. Medical anthropology

may help clarify challenges that might arise during treatment, such as resistance to certain treatments or reluctance to take action when solutions are offered. Problems of communication and so-called non-compliance—issues that exist in hearing care and most other healthcare professions—may be eased through an enhanced appreciation of the ways in which various outside factors influence the perception and management of health issues.

THE ENCOUNTER MODEL

From the clinical literature, it is clear that the clinical encounter (the first meeting between healthcare professional and patient) is often problematic, marked by confusion and misunderstandings. It is reported that the communication between the patient and the healthcare professional appears to be a challenge because practitioners in all areas of healthcare have difficulty addressing patients in an understandable language or because they lack the time, the will, the qualifications, or the competence to address patient concerns.

The encounter model (see Figure 1) provides valuable insight for hearing care professionals that will enable them to reflect on the clinical encounters they have daily with patients and "reframe" their practice to achieve a truer patient-centered focus. Using the encounter model can

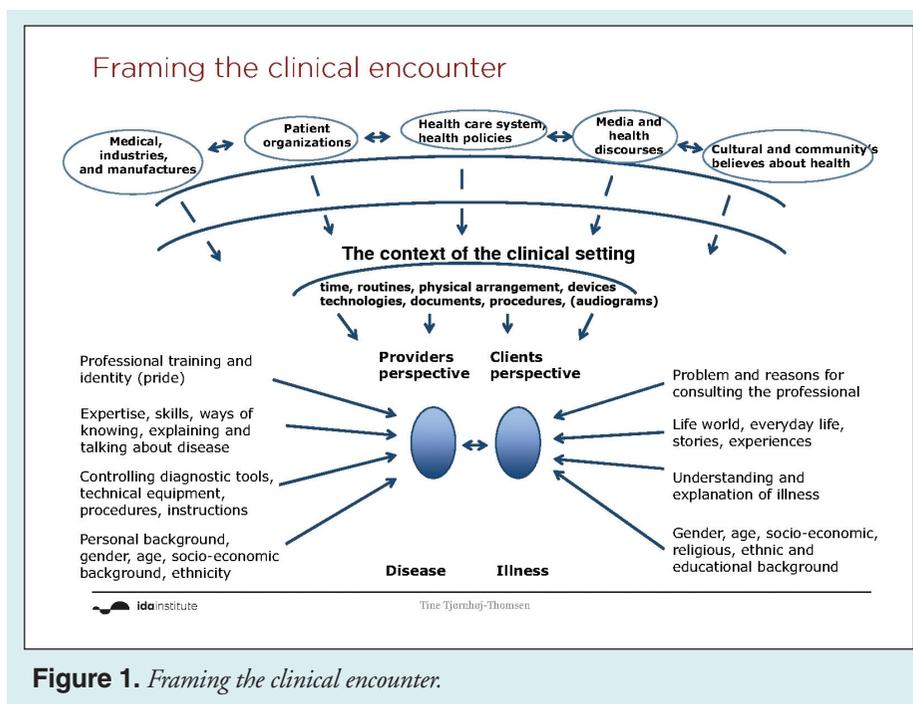


Figure 1. Framing the clinical encounter.

help practitioners obtain a clearer understanding of the role of the various personal, professional, and cultural factors that define each person's unique experience of hearing loss. The model also helps practitioners reflect on their own backgrounds and the preconceptions they bring to the clinical encounter.

Research (e.g., Mattingly¹) shows that people are better able to cope with challenges of all kinds when they receive care that combines shared understanding and an appreciation of their unique and very personal experience of the health issue. Achieving a better mutual understanding of the hearing loss problem for the patient through an open, patient-centered interaction is vital for the patient's understanding, trust, and hope of a positive outcome.

EXPLANATORY MODELS

Explanatory models in medical anthropology are analytical devices used to enhance awareness of the different positions that are brought into the clinical setting by any of the actors—the hearing care professional, the patient, or family members or significant others—participating in the encounter.

These positions may include preconceptions about the cause of a health problem, the diagnostic criteria, and the treatment options. They may also refer to beliefs and expectations, norms and behaviors, and they can extend to the understanding of the meaning of health and illness, therapeutic activities, and outcome evaluation. Explanatory models may be partly conscious and partly subconscious. And they draw on belief systems characteristic of the culture at large.^{2,3}

In any clinical encounter, the actors may hold different perceptions leading to misunderstanding and confusion.

Disease versus illness

The explanatory model approach is inspired by the work of Arthur Kleinman, PhD, of Harvard University, a leading medical anthropologist. His approach to exploring the distinctions between *illness* and *disease* provides an excellent illustration of the importance of understanding the various viewpoints at play in the clinical encounter.

EXPLANATORY MODEL IN ACTION

The concept of a theoretical model that can be used to foster collaboration and understanding among diverse viewpoints is an apt description for the workings of Ida Institute's first seminar series, "The Process of Defining Hearing."

The seminar structure is built around the belief that participants have much to learn from one another and that no one viewpoint provides a definitive answer. As a result of the seminars, more than 65 hearing care professionals from 13 countries were able to use their new-found knowledge to develop a practical, flexible "Possible Patient Journey" tool applicable to a wide range of professional situations.

To obtain the "Patient Journey" tool, go to www.idainstitute.dk.

According to Kleinman, the term *illness* is used to indicate how the patient and the members of the family or wider social network perceive, live with, and respond to the symptoms and disability. It also defines the difficulties and distress the illness creates in the patient's everyday life and the experience and the meaning of the symptoms and suffering, ranging from fear and shame to life disruption and social exclusion. This model also reflects the patient's own characterization, explanation, and ideas about how best to cope with the situation.

The term *disease* is used to describe how the patient's problem is viewed by healthcare providers, who often perceive the problem as a malfunctioning of biological and/or psychological processes. The practitioner then recasts the illness in terms of medical theories of the disorder. Typically, this is what practitioners have been trained to see through the theoretical lens of their practice and through the nomenclature and taxonomy of their profession (Kleinman 1980: 72-73²).

Understanding explanatory models, such as the model that helps distinguish between illness and disease, may help healthcare providers achieve a better appreciation of their patients' viewpoints. It may also help them to better reflect on their own practices and the ways of explaining the problem.

Each encounter is unique

While hearing and hearing loss may be talked about in objective terms, for instance by the audiogram and other test results, in terms of individual patients and their everyday life and needs, reaching a consensus about what constitutes a definition of hearing for each individual depends on perspective and context.

It is a process involving different people with different interests and concerns.

The meeting between healthcare professional and patient is the central component of the encounter model. The model facilitates reflection on the issues that each party brings to the meeting as well as the stereotypes or preconceptions held by both practitioner and patient that may make it difficult to draw out the true story of the patient's individual situation.

What brought the patient in to see the professional? What has been the patient's "discovery process" and what precipitated this process? Did the patient seek help as soon as he realized there was a problem or did he stay at home for a period of time? Often there is a gender differential at work, with men staying home longer before they consult a professional. Other factors also impact the patient's perspective, including ethnicity, social status, and income.

THE PATIENT/CLIENT PERSPECTIVE

The patient's world—his everyday life—is also a key contributing factor in the clinical encounter. Health problems are always contextualized in the everyday life activities of the client. While the practitioner is trained to focus on the problem in audiological terms in order to solve it, the client mobilizes other, more complex relational concerns.

Hearing loss and its management cannot be separated from the broader circumstances of a patient's life. The patient's goals and strategies constantly interact with everyday life, actions, and concerns. Patients try to fit the recommended behavior into the complexities of their everyday life. Their inability to do this often has nothing to do with

any lack of motivation or knowledge. Rather, non-compliance is often related to the demands of everyday life, for instance family obligations. It is simply a question of being unable to do what is recommended in the context of their everyday life.^{1,4}

Patient narratives

The audiologist cannot directly experience the day-to-day life of the patient. He or she must discover it through professional questioning and frequently, and most telling, through the stories people relate about their experiences and how they are effected by them. Professionals must rely on what they are told.

When patients share their stories, they are trying to make sense of their situation. It is important to realize that stories are edited versions of reality, a type of “impression management.”⁵ They are almost always mediated by the context and by the situation.

By telling stories, patients are trying to project an image of who they are or who they want to be. They are creating their own version of the story, which in this context is the story of hearing loss. Patients knit together different episodes and actors to present a coherent and meaningful story. This gives them the opportunity to present themselves as they were at one time and as the person they want to become.¹

The narrative perspective can be useful in a clinical setting because it allows the healthcare provider to grasp some of the patient’s journey. But it is critical that practitioners remain aware that this is a selective presentation of the patient’s reality.

Encountering the family and others

While most clinical encounters are between the provider and the patient, patients will often bring their spouse or close relatives. These people also have to handle their worries and their diverging understanding of what is at risk. The healthcare professional manages these concerns in the context of the relationship with the patient. This can be challenging because often practitioners are uncertain what is really going on inside the family.

When I interviewed childless couples in their homes for my work on infertility, it appeared that each member of the couple had a very different experience of the same clinical encounter and of what the doctor had said.⁶ The difference in experiences is striking. In fact, what they hear is often closely associated with their own hopes and fears and their perception of their responsibility in the infertility issue.

It is important to be aware that when patients leave the clinic with their families, they will go home and discuss the meeting. They will probably not agree and the next time they are in the office they will have many questions.

Other influences

Patients bring to the clinic different types of knowledge they have gathered from outside sources. This knowledge, which may come from the Internet, from media, and from family and friends, influences the patient’s perspective on the problem and how to solve it. These homemade perspec-

tives may sound irrational to the clinician, and healthcare professionals are often eager to correct them as mistaken. But these perspectives can guide the patient’s actions and practices and affect how treatment behaviors are interpreted and enacted.

All of these factors—daily life, stories, and sources of knowledge—feed into the way patients understand and explain their health problem and play a significant role in the clinical interaction.

THE PROVIDER’S PERSPECTIVE

The hearing care professional’s point of view is also a critical factor in the encounter model. Clinicians bring their gender, age, socio-economic status, religion, ethnicity, educational background, morality, and values to the interaction. Their professional training, socialization, and professional identity add further complexity to the interaction.

Hearing professionals are trained to make sense of hearing problems through a shared set of assumptions and rules based on scientific methods. They learn to regard and treat their patients in a way defined as appropriate by the culture of their profession.³ They bring expertise, knowledge and particular ways of knowing, and a professional perception rooted in audiology and skills. They also bring professional commitment and pride.

Equally significant, it is the professional who is in charge of the diagnostic technology, the technical procedures, and the technology solutions offered to the patient. Researchers have underlined the importance of the technological imperative, explaining that it is tempting to choose available technology as the only solution in the struggle to deal with a patient’s hearing loss.⁷

Anthropology studies have pointed out that technological procedures offer a strategy to remove the uncertainty of illness and treatment.⁷ Technical solutions within the healthcare profession may also be a way of dealing with clinical uncertainty. They discipline the patient and the practitioner and instill a sense of control.

Clinical setting

The clinical setting itself is not merely a backdrop for the clinical experience, but an integral part of the relationship between the practitioner and the patient as illustrated in the model³ (Lazarus 1988: 49). The clinical setting can determine how people act and how much power professionals wield.

The physical and esthetic arrangement of the clinic—the waiting room, the examination room and how they are organized, where people sit and wait—also contributes to the experience of the clinical encounter. The allocation of power and control and the division of labor between different professionals in the clinic may also influence the interaction.

Clinical procedures and routines also play a role. In the clinical interaction, staff seldom pay much attention to the routines and procedures. Other items—documents, instruments, pamphlets, and technologies—also mediate the clinical experience. For example, in hearing care, the audiogram plays a significant role in the interaction between patient and professional.

Time management and negotiation are also factors. When a patient takes out a paper with questions to ask, that's a way to negotiate time in the clinic.

Other external factors affect the clinical encounter. Healthcare companies, healthcare technology and equipment, practical business concerns, and marketing of products all play a significant role in the encounter. There is also the healthcare system—the quality of the care provided and economic concerns such as whether patients must pay for the services or are covered by insurance.

BENEFITS OF THIS APPROACH

The challenge of developing a truly patient-centered focus in a busy and diverse practice makes the encounter model both a theoretical and a reflective tool that enables hearing care professionals to benefit from research and clinical applications in other healthcare disciplines. The goal is not to reach a definition of hearing and hearing loss, but rather to provide tools that help practitioners reflect on the defining process.

Communicating and exploring beyond the standard clinical approach can build a more productive and honest relationship. It can counter inclinations to think in terms of stereotypes and generate trust.

It is clear the encounter model can contribute to patient-centered care by increasing the potential for patient satisfaction with consultations, by engaging patients in collaborative working, and, ultimately, by generating outcomes tailored to meet the needs and wishes of the individual patient.

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