In audiologic rehabilitation, we advocate the need to help patients self-manage their hearing impairment. Self-management is seen as a cost-effective way of ensuring adults are healthy and optimally participating in society. Self-management is perceived as a desirable behavior that a health practitioner teaches his or her patient; it is a measure of how well a practitioner does his or her job. It can be argued, however, that people with chronic health conditions are constantly self-managing irrespective of contact with a health practitioner (Pulvirenti, McMillan, & Lawn, 2014). Once a patient comes to see a health practitioner, the health practitioner’s role is to empower the patient to take action that will optimize health and participation. Unlike self-management, however, successful patient empowerment is influenced by the nature of the patient-practitioner interaction. That is, the quality of the health practitioner’s communication skills and interactional behaviors can influence the success of the encounter and the patient’s outcomes. Patient empowerment can be achieved by providing patient-centered care (PCC).

This article will summarize the literature on the influence of patient-practitioner interactions and PCC, explore current evidence regarding the nature of audiologist-patient interactions, discuss practical implications, and provide practical strategies to maximize the quality of patient-practitioner interactions in the workplace.
conditions, such as hearing impairment. Patient-centered, patient-practitioner interactions have been associated with improved patient outcomes, such as treatment adherence, satisfaction, and reduction in psychological and physical impairments, and practitioner outcomes, such as increased satisfaction and fewer malpractice claims (Haskard Zolnierek & DiMatteo, 2009; Robinson, Callister, Berry, & Dearing, 2008; Roter et al., 1997; Levinson, Roter, Mullooly, & Frankel, 1997). More recently, strong arguments have been made about the positive financial imperative for providing PCC (Charmel & Frampton, 2008).

2. Patient-centered, patient-practitioner interactions in audiologic rehabilitation

PCC is highly applicable to audiologic rehabilitation. It has recently become clear that psychosocial factors relating to the individual with hearing impairment (i.e., family support, self-efficacy, attitude to hearing aids and self-reported hearing impairment) outweigh the influence of the diagnosed degree of hearing loss or the device fit on obtaining successful audiologic outcomes (Hickson, Meyer, Lovelock, Lampert, & Khan, 2014; Meyer, Hickson, Lovelock, Lampert, & Khan, 2014). This poses a challenge for the hearing rehabilitation sector as the current delivery system focuses on the degree of hearing loss followed directly by the provision of hearing aids, leaving little scope for empowering the patients to make decisions or change their behavior. It also doesn’t address patients’ and families’ functional needs holistically, as is required in PCC.

The technology-centeredness (i.e., patient-practitioner interactions focused on provision of technology) of audiologic rehabilitation has been criticized for decades; yet only recently has the extent and impact of such interactions been empirically documented (Ekberg, Grenness, & Hickson, 2014; Ekberg, Meyer, Scarinci, Grenness, & Hickson, 2014a, 2014b; Grenness, Hickson, Laplante-Lévesque, Meyer, & Davidson, 2015a, 2015b). By filming more than 60 initial consultations between audiologists and adult clients (and companions in 17 cases), we were able to explore the presence and nature of communication that would be indicative of technology-centered or patient-centered audiologic interactions [details on how this analysis was undertaken is reported elsewhere (Grenness et al., 2015a).

To evaluate the nature of audiologist-patient/companion interactions, results were juxtaposed against a recently published definition of patient-centered audiologic rehabilitation (Grenness, Hickson, Laplante-Lévesque, & Davidson, 2014). According to this definition [presented visually in Figure 1], development of a therapeutic relationship is central to PCC: that is, building trust, seeking psychosocial information and responding to emotional needs. The therapeutic relationship is supported by effective bilateral information exchange [exploring patients’ experiences and giving information appropriate for the patients]; involvement in decision-making [asking for the opinions and involvement of family members]; and by offering solutions individualized to patients’ needs. This definition of PCC is consistent with others described in medicine and are in line with other research findings of patients’ preferences for audiologists’ interactional skills (Mead & Bower, 2000; Laplante-Lévesque, Hickson, & Worrall, 2010; Poost-Foroosh, Jennings, & Cheesman, 2015).

The results of the series of studies exploring audiologist-patient/companion communication confirmed the frequency of technology-centered, patient-practitioner interactions in audiologic rehabilitation. A comparison of different communication characteristics contained in device-centered versus patient-centered consultations is presented in Table 1.

A summary of findings is presented in Figure 2. The first notable finding was that the therapeutic relationship was poorly developed or not maintained: audiologists asked few psychosocial questions, and when patients raised concerns [mostly about hearing aids], these concerns were
<table>
<thead>
<tr>
<th>Interaction Characteristic</th>
<th>Practitioner-centered/device-centered</th>
<th>Patient-centered</th>
</tr>
</thead>
</table>
| Relationship building      | • Little time invested in relationship building  
                            • Superficial social discussion  
                            • Avoidance of psychosocial topics | • Time and effort invested in building and maintaining relationship  
                            • Responsive and empathetic |
| Control of structure and focus of consultation | • Sits with the practitioner | • Shared between two experts |
| Direction of information exchange | • From practitioner to patients | • Both directions |
| Content of information exchanged | • Device-related and technology-related  
                            • Complex and pitched at a high literacy level  
                            • Content not individualized to patients’ preferences | • Mix of bio-psychosocial and biomedical |
| Involvement in decisions | • Practitioner leads and makes decisions | • Shared between two experts |

Table 1. Comparison of communication characteristics within practitioner-centered or technology-centered versus patient-centered consultations.
rarely addressed or explored (Ekberg, Grenness, & Hickson, 2014). A second notable finding was that information exchange was typically controlled and dominated by the audiologist: audiologists asked the majority of questions, questions were typically asked in a closed-ended fashion, and in management planning, hearing aid information dominated and was presented in a complex and didactic fashion (Grenness et al., 2015b). Thirdly, alternative options to hearing aids were rarely provided; the patients’ opinions were rarely sought and when a companion was present, he or she was infrequently involved or engaged in decision-making (Ekberg, Meyer, Scarinci, Grenness, & Hickson, 2014b). The fourth pertinent finding was that consultations unfolded in a structured, preformulated fashion, which left patients with little control over the nature of their care. The subsequent outcome of these consultations was that fewer than 60 percent of patients who were recommended hearing aids decided to obtain them at that time.

While all audiologists participating in these studies were kind, friendly and technically competent, these findings revealed a lack of patient-centered audiologist-patient interactions (Grenness et al., 2015a; 2015b). Similar themes have been reported in the context of pediatric audiologic counseling and when examining the complexity of hearing aid counseling specifically from a health literacy perspective (Watermeyer, Kanji, & Cohen, 2012; Nair & Cienkowski, 2010). All of these studies conclude that the nature of audiologist-patient interactions is likely to be implicated in patient empowerment or behavior change.

3. Practical implications and strategies

A major implication of these findings is that despite increasing attention on PCC in audiology, translation into clinical practice has not yet occurred. These findings indicate a need to consider the impact of audiologist-patient interaction on the patients’ help-seeking behaviors, uptake and success with hearing rehabilitation.

From a clinical perspective, four areas for consideration are highlighted:

1. The need for a holistic approach to consider the biological, psychological and social aspects of an individual.

2. The need to engage with the patients’ and their families’ psychosocial concerns.

3. The need to share control not only in making decisions, but also in the structure of the consultation (i.e., who leads the conversation topics and frequency of interruptions).

4. The need to involve and engage with family members.

To shift from technology-centered to patient-centered audiologic rehabilitation, there are many simple strategies that can be implemented including:

5. Open the consultation with two open-ended questions and let the patients talk without interruption for at least a minute. Once a relationship has been developed, ask questions about the impact of the hearing impairment on the patients’ lives. Ask if they feel they or others are coping, and if they see any solution to their difficulties. Present alternative options to hearing aids and ask for their input before making a recommendation.

6. Listen for patients’ concerns, and if you hear concerns, acknowledge them by showing genuine empathy and asking an open-ended question to encourage him or her to elaborate. Address concerns once you understand what those concerns pertain to.

7. Take note of who speaks the most in your consultations and if the patients are interrupted while talking. Offer the patients time to talk by leaving pauses after questions and allowing opportunity to ask questions regularly.
8. Specifically provide family members with the opportunity to share their concerns and set their own goals to minimize disagreements. Seat the family members at the desk next to the patients.

9. Up-skill in personal-adjustment counseling. Seek counseling courses, professional development and access online resources.

In order to implement these changes, it is important to reflect on your current practice. A powerful reflection tool is to film your interactions (with patients’ consent) and watch them. The Ida Institute has a number of reenacted clinical videos that you can access for free at http://idainstitute.com/toolbox/video_library/clinical_reenactments/ to use as a reflective tool. These videos provide a good demonstration of similar communications observed in the studies reported here.

Concluding remarks

It is acknowledged that while audiologists are ultimately responsible for their own interactions with patients, many of the complex issues involved in implementing PCC cannot be addressed at the practitioner level alone. Consistent with organizational change literature, changes at the patient-practitioner interaction level are affected by macro factors such as organizational structure and reimbursement systems. In audiology, organizational structure might undermine an audiologist’s ability to provide PCC. For example, if an organization provides commission for specific tasks with little consideration for how well the task is performed or if reimbursement is received for the device rather than the success of the intervention, then the audiologist-patient interaction may be negatively impacted.

Outside of audiology, the financial value of providing PCC is widely acknowledged. Despite this, current models of funding in audiolocic rehabilitation reward hearing aid provision in isolation. They fail to recognize that this model inevitably reinforces a device-centered model of patient-practitioner interaction where the treatment is prescribed for the ailed body structure. In contrast, when a hearing aid is considered a tool for the hearing healthcare practitioner to offer as part of a solution to communication or participation impairment alongside support, education and a therapeutic relationship, the patients are more likely to be empowered to accommodate the device into their routine.

In closing, patient-practitioner interactions that occur in a patient-centered fashion are more likely to lead to empowered patients. Recent research exploring the nature of audiologist-patient/companion interactions found a paucity of patient-centered care in audiolocic consultations. Thus, there are significant opportunities for audiologists to be empowered to undertake their own behavior change and shift their patient interactions from device-centered to patient-centered.
References


