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The Importance of Framing at the Beginning of an Review Dialogue

Bahrs O*

Umbrella Organisation Salutogenesis, Göttingen, Institute of General Practice, University of Duesseldorf, Germany

***Corresponding author:**

Ottomar Bahrs,
Umbrella Organisation Salutogenesis, Göttingen, Institute of General Practice, University of Duesseldorf, Germany, Tel: +49 55142483;
E-mail: obahrs@gwdg.de

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1. Abstract

Long-term care of patients with chronic conditions in general practice rarely focuses on the treatment process. A specific interaction tool, the Review Dialogue (RD), has been developed to integrate patients' health-related problems/risks as well as coping strategies and to agree upon shared treatment objectives assuming that periodical RDs will help to achieve them. Initiated by the GP, the RD changes the role expectations of the patient and doctor. Therefore, the framing of the encounters is of particular importance.

Methods: GPs were randomized: intervention group (extra RD training, 4 RDs/year with 20 patients with chronic conditions) or control group (usual care). The qualitative analyses are based on the evaluations of a subgroup that documented some RDs by vid- eo. Twenty courses were analyzed sequentially and comparatively using structural hermeneutics. The paper focuses on the initial and closing sequences of the encounters.

Findings: The initial sequence sets the tone for the further dialogue. The participating GPs initiate the RD in different ways: Often, they refer to the existing management of chronic disease (DMP), asking the patients how they cope in everyday life. GPs asked the patients to develop health objectives for the next 12 months, which are rarely fundamentally new, but sometimes mod-ified ways to achieve them. Other GPs begin the RD by resumingthe treatment history of the last months or years, transitioning to the current state of health. Finally, some GPs take into account the actual situation of the patients starting with an open question. These latter opening variations leave room for the patients to ex- plain their point of view, allowing them more easily to re-evaluate their objectives. Only a few GPs explicitly say that they wish to getto know their patients better to support them. In these interactions,

the patients strive to make their situation transparent and contribute to the success of the treatment.

Discussion: The process of the interaction seems to be "determined" by the 'starters'. We discuss which "factors" contribute to the realization of the specific kind of opening and consider possi- ble relationships between opening and specific closing procedures.

2. Background

Long-term care of patients with chronic conditions in general practice rarely focuses on the treatment process [7]. A specific in-teraction tool, the Review Dialogue (RD), has been developed to integrate patients' health-related problems/risks as well as coping strategies and to agree upon shared treatment objectives assuming that periodical RDs will help to achieve them. Initiated by the GP, the RD changes the role expectations of patient and doctor [1, 13]. Therefore, the framing of the encounters is of particular impor- tance.

Each social interaction is framed by rules that usually remain implicit and must be addressed only in the case of "disturbances" [8,10, 12]. So we expected that an RD follows the rules applied on

- social interaction at all;
- doctor-patient encounters;
- the repetition of contacts in general practice;
- participation in the research project and video recording;
- and finally, the specific review dialogue.

We expected that the framing performed in the opening would be echoed in the closing procedure (Table 1). Therefore, it is conceiv- able that the relevant steps of the procedure are accompanied by commentaries concerning the relationship.

Table 1: Dimensions of framing in the Review Dialogue

	Opening	Closing
Taking part in the study	• Informing • Motivating • Stressing the surplus for both the parties • Agreement	• Thanks for participation • Evaluation of the dialogue situation • Confirmation of participation in the study and further procedure
Social Interaction	• Greeting	• Farewell
Video-recording	• Starting the recording • Ensuring the operation • Confirming agreement with recording • Data security and anonymity	• Ending the recording of the conversation • Confirmation of willingness to use the recording (or to delete it)
Consultation	• Transition from everyday life to the medical world – coping with health related problems • Taking the role of GP and patient • Identification of the treatment problems • Diagnosis and agreement on the treatment options	• Development of a treatment plan • Handing over a prescription, etc. • Discussing the integration of therapeutic measures into everyday life • De-specification of roles
Review Dialogue	• Patient as an expert, empowerment • Accounting for the overall situation of the patient and the doctor-patient-relationship • Agreeing on - patient's priorities - health related goals	• Documentation of agreed goals • Protocol and signature by both parties • Arrangement of a followup appointment • Aggreeing on - ways to achieve the goals - responsibilities of the parties involved

3. Methods

The evaluation presented here is based on the BILANZ (BALANCE) study conducted in 2011-2015 in Germany (see German Register of Clinical Trials, DRKS00004442).

BILANZ was a cluster-randomized intervention study investigating with a mixed-method design whether and how GP's long-term care of patients with chronic conditions might be improved by a new consultation format, the RD. The RD mainly focuses on improving the orientation towards mutually negotiated health goals. While the purpose of the quantitative survey was to provide a comparative description of shared health goals and determinants of their achievement, the qualitative study focused on the process of the doctor- patient-interaction in order to identify typical patterns of the negotiation and their latent meanings.

The study design was reviewed by the Ethics Committee of the University of Düsseldorf and was approved in April 2012 (registration number: 3740).

The BALANCE study involved a total of 52 general practitioners and 438 patients. Within one year, the doctors held 2-4 goal-setting interviews with patients who voluntarily participated. Inclusion criteria for the patients were: At least one chronic problem, age <70 years, and adequate German language skills.

For all RDs, the health goals agreed upon, as well as the pathways to the goal achievement, were documented. The patient and doctor assessed the extent of the goal achievement from their point of view independently. After the last RD, the patient and doctor answered whether they wished to continue the RDs. The data of a total of 286 patients and 36 physicians were evaluated.

GPs were randomized: intervention group (extra RD training, 4 RDs/year with 20 patients with chronic conditions) or control group (usual care).

For the additional qualitative study, GPs were asked to record every fourth consultation on video. Participation was voluntary, and patients and physicians gave their written consent that the recorded interviews may be used for research, education and training. The conversations were recorded with a permanently-installed camera. A total of 14 physicians and 50 patients participated in this part of the study. Our deliberations are based on the in-depth analysis of 20 wholly documented case histories (2-4 videotaped RDs each; total: 62 RDs). The analysis was carried out sequentially and comparatively using structural hermeneutics (Oevermann 2000). Here, we focus on the opening of the first RDs.

4. Findings

The configuration of the opening situation and the configuration of the doctor-patient relationship refer mutually to each other. On the one hand, the doctor-patient relationship is staged from the beginning for every level of opening (table 1). On the other hand, reframing is possible during the RDs and may be accompanied by a change in the doctor-patient relationship.

The participating GPs (and their patients) initiate the RD differently. We can distinguish the following four patterns:

1. RD as a common challenge. The situation is transparent and

designed as a process of learning together (example 1).

→ new relationship

2. GP invites the patient to an expansion of the current (disease management) program. The situation is designed as an administrative act, in which the living environment of the patient is explored, but ultimately no bridge between the medical world and everyday life is struck (example 2).

→ consistent relationship

3. GP invites patient for an enhanced overall treatment in the face of a stagnating course. GP guarantees transparency, protects the patient, and enables experiences of change that can be transferred to everyday life (example 3).

→ deepened relationship

4. GP invites the patient for a detailed discussion without clarifying his objectives and/or the patient undermines the RD at the beginning (not shown here).

→ different profiles (some relationships broke up)

Often – but not always - the pattern of framing, identified in the opening situation, is answered almost echo-like in the closing procedure (table 1).

Where this is failing, a kind of misframing results and the social interaction cannot successfully be completed on the corresponding stage [2].

Example 1: *RD as a common challenge*

GP1: recording, now we are...

P1: Now we're on the air.

GP2: Exactly. So now we forget about that because that's always stupid.

P2: That's right.

GP3: So we do not know who looks so far.

P3: Whether anybody looks at all, you do not know as well.

GP4: Yes, exactly. Yes. Um, I have already explained a little bit what it is about. / Hmm? / It's just to find out whether talking like that does affect people. I think that we both know because of our professions [P works as a nurse] that it is so. /Yeah./ Um, but how to measure that impact? Let's wait and see; I'll inform you when I've got the results, in two years, I think.

P4: That's nice.

GP5: Uh yes, and in order to find out about this, we have to do it in a certain way; we'll meet several times. /Hm./ Four times a year, today is the first time. And we will reflect on what is personally important to you for your health. /Yeah../ In the broadest sense, bio, biologically, so as far as regards the body, the soul and the social environment. Um, what do I consider to be essential, and where do we meet each other on a halfway [P laughing] to set goals? /Yeah./ Um, to figure it out, we should find out first how the last year was for you. What does that matter for health and disease? Have any events been bad for you? Perhaps you can tell me a little bit about it. And the good ones as well, of course.

P5: (laughs) How was it? Sick, all right, with the thyroid, that was before last year already, I think, right? /Yes./arterial hypertension, well, no question. What was very bad in this context was that I googled the thyroid gland, which was quite terrible; you shouldn't do that. [Laughing]

GP6: You have not told me! /No.[Laughing] / Nice that we are meeting tonight.

Example 2: RD as expansion of the current treatment program

GP1: So! This is the recording of doctor's office 02, patient 02, internal IT 1111, consultation at (date, OB). Okay? Now we have done the paperwork, Mrs H., and now we come to the content. Namely, we take the time to think about it, perhaps about twenty minutes: you've got sugar disease /Yeah./ and the high blood pressure, struggling with your weight, maybe there are also some other things, at work? Or in the family, which you may want to change?

P1: Less stress at work.

GP2: Less stress at work?

P2: This is very bad at the moment. / Ah, yes? / This is actually very, very, very bad. /Hm./ I'm fed up! But I can not change it.

Example 3: RD as enhanced overall treatment

GP1: (...) You won't get irritated by the camera; I have now made the experience with the other talks uh, when - after a few minutes / you forget it effectively/ Yes, exactly.

P1: I've got no great excitement (.). [Laughing]

GP2: During the conversation, I would like not to mention your name /Yeah./ but I always a risk /Yeah./ to do that, /Hmm./ but they'll fade it with a beep sound: Normally, I use to address you with your name./okay./ Thank you, um, very much for the conversation;/Yes / I alternate shortly before:

This is a consultation of practice 03, patient 03, 3333. /Hmm./ Yes. Today, it is Monday (date, OB). Yes, thank you very much for agreeing to participate in this conversation /Yeah./ /Yeah./ I have asked you, just because you have some health problems / Hmm./ which are chronic and recurring. /Yeah./ First, as you have already mentioned, is hypertension. / Correct! / And, um, the other one is your / depression! / your recurring depression.

P2: Right, and we do not get control, at least a bit.

GP3: Yes, you have just briefly addressed that last weekend your blood pressure was very high /Yeah./ and that you had the feeling again to feel it in your head. /Right./ Yes. What do you do when you realize that? How do you manage that in your everyday life and at the weekend? How's that for you?

P3: So, this is always so much stressful, I then try to sleep longer, and of course, I can not do as much at home, and I'm very

sluggish on those days, so, okay, I force myself because of the children, to do things but I have actually no power, but I think these are my duties, and I /Hmm./ am guided by the clock just in order not to be out of time. 'You have to get up now; you have to make,' / Uh-huh. / And then it works somehow. And then [laughs] the day is managed somehow, thank God.

5. Discussion

What is missed in the beginning is difficult to correct later. However, if the beginning is well managed, the RD can enhance progress in the doctor-patient relationship, and shared perspectives can be created, both partners being accepted experts [3-6].

Reframing is possible at any time but requires extraordinary effort and always goes hand in hand with a redefinition of the doctor-patient relationship [9].

The significance of the closing procedure is underestimated [13]. Nevertheless, completing the "gestalt" is essential and may open a new and extended frame [9].

Unfortunately, we have not yet systematically analyzed our extensive interview material from this point of view. However, single case analyses of initial interviews have strongly confirmed the importance of the closing procedure. Furthermore, they have led to an extension of the recommendation for action on initial anamnesis, prepared by a group of experts on behalf of the German Society for General and Family Medicine (currently still in progress).

So we conclude, that it is worthwhile to invest in the opening and the closing procedure of a Review Dialogue as in any doctor-patient encounter. Further studies are needed.

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