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Teaching About Better Family–Clinician Partnerships in High-Risk Pediatric Asthma Care

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Abstract

Family–clinician partnership including communication, trust, respect, and power leveling is essential in pediatrics. Our case study illustrates elements supporting/hindering partnership in a high-risk urban pediatric asthma clinic. Data from observation of a 100-minute visit were qualitatively analyzed by applying codes to themes, using family-centered principles. Three key categories emerged from examining interactions and their sequencing: (1) partnership supported, (2) partnership missed, and (3) partnership hindered. Practitioners must become more sensitive to families' lives and skilled in family-centered care delivery. Clinician education about partnership can help with negotiating workable treatment strategies for complex conditions such as asthma and reduce health disparities.

Keywords

patient/family–clinician partnership, family–clinician communication, family-centered care in pediatric asthma, pediatric asthma management

Introduction

A collaborative relationship between family and clinicians is vital in pediatrics (1-3). Partnership can support or discourage patient and family treatment participation (4); partnership is associated with improved adherence, satisfaction, and positive outcomes (5-8). It develops from communication, trust, mutual respect, and power leveling (9).

We present a case from a high-risk pediatric asthma clinic illustrating such interpersonal interactions. Qualitative data from direct observation of this encounter were analyzed by applying codes to themes, using family-centered principles (10). Consensus coding incorporated diverse perspectives of a multidisciplinary team examining interactions influencing partnership. Four vignettes: "Smoking Coat," "How Are Things Going?," "Hot Cheetos," and "Are We Crazy?" are presented from 1 clinical visit. Interactions involve 1 family with a resident physician and an attending physician.

Case Presentation

John, a 13-year-old African American boy with severe asthma, receives treatment in this clinic. Patients are mainly African American; staff are not. "High risk" involves exacerbations, frequent hospitalization, intensive care unit admission, intubations, and exposure to smoking and/or psychosocial risk factors. These can include poor housing,

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poverty, foster home placement, and poor adherence to medical regimen due to environmental stressors.

John and his mother have come for 1.5 years and report satisfaction with clinic staff and care. This visit was 100 minutes, average for the clinic.

Smoking Coat—Partnership Supported

A resident physician entered the room, introduced herself, and shook John's and Stacy's hands. She asked John what medications he was taking, how his asthma was, and whether he ever missed doses. John tried to remember; the resident prompted by asking questions such as "How many doses have you missed in the past week?" She asked John about symptoms and allergies. The resident asked Stacy whether she smoked. Stacy said she smokes but outside. The resident suggested Stacy to have a Smoking Coat. Stacy could wear it when she smokes and then leave it outside.

Analysis

Communication: The resident addresses lifestyle issues nonjudgmentally and offers a suggestion Stacy agreed to consider.

Trust: An accepting, respectful environment is fostered allowing trust. It permits Stacy to reveal what both know is unfavorable information.

Respect: The resident demonstrates respect by making a helpful suggestion that may reduce harm, without evaluating the smoking habit. If done sensitively, a recommendation for a smoking cessation program that is a longer term solution could have been respectful and also consistent with good clinical care. The nature of the relationship determines what recommendations can be respectfully conveyed and heard.

Power leveling: By offering a suggestion, possible solution negotiation can emerge.

How Are Things Going—Partnership Supported

The attending physician Dr G. entered the room. Dr G. knows this family from prior visits; she knows Stacy has a diagnosed neurological condition. Dr G. noticed Stacy's cane, asked how Stacy was doing and about her symptoms. Dr G. asked about how John was doing and whether they had problems or concerns.

Analysis

Communication: Physician and mother engage in a conversation about life at home and different family members' health. The physician shows broader concern about the family's health issues, not just asthma.

Trust: Existing trust enables information sharing about a sensitive topic, Stacy's health condition.

Respect: Respect is shown by how the physician addresses Stacy. The physician shows understanding of what Stacy balances in her roles as caregiver, mother, and patient.

Power leveling: The interaction appears more balanced with eliciting and exchanging information.

Hot Cheetos—Partnership Missed

The resident asks John what his favorite subject is in school. Although John answers "math," the resident does not comment. Later, when Dr G. asked about John's heartburn and acid reflux, she discusses what happens when John eats Hot Cheetos. Dr G. asked why John continues to eat the food if it bothers him. Although Dr G. attempted to use humor when asking John about this snack, she seemed frustrated with John's lack of response.

Analysis

Communication: Although John replies to the resident's question, the resident misses the opportunity to connect. This information could have been used in considering John's treatment plan implementation. Clinicians could have complimented John for caring about math and mentioned how it involved counting and keeping track of things—skills that would be useful in John's self-management of his medication regimen. Additionally, attention to John's answer could reinforce his interest in engaging in other conversations with the clinicians. Communication breaks down further as the attending physician questions John about his choices; John does not respond.

Dr G. is confused and frustrated by John's behavior. By not attempting to understand John's reasons for eating the Hot Cheetos (eg, because he likes the taste, it is what other teenagers do), the physician and John did not achieve a shared understanding.

Trust: Trust is broken down. The physician does not trust that John makes good choices, and John does not trust the physician to share his thoughts/motivations.

Respect: Although the physician is concerned about John's choices and their ill effects on his asthma and health, her approach interferes with communicating respect.

Power leveling: The physician provided information and education to the patient previously; she expresses frustration with the patient's nonadherence. This impedes the opportunity to engage John in a reciprocal discussion.

Do You Think We Are Crazy?—Partnership Hindered

Dr G showed John a picture chart with different medications and inhalers. Dr G asked whether John was using what they gave him. John said he was not. Dr G told John he needs to take it consistently because they gave it to him. If he does not use it properly, he will get white patches in his mouth. Dr G. asked whether he wanted to get white patches. Dr G. asked again why John does not use it. She said it is good for John. Dr G. asked John whether he thought they (the clinicians) are crazy at the hospital for giving it to him. Dr G. then asked John and Stacy whether they had any questions for her, they replied no.

Analysis

Communication: Dr G. and John attempt to talk about medications. Communication becomes increasingly difficult, and information exchange is lacking. No explanation for what the white patches are or their consequences is offered. This might contribute to John's nonadherence.

Frustration builds as the clinician's and patient's viewpoints differ and communication shuts down; the family asks no further questions.

Trust: Trust is challenged. John is not comfortable disclosing why he does not use the inhaler, and the physician does not make an adequate attempt to understand physical, social, or other reasons.

Respect: Respect is compromised as the physician questions John whether he thinks the doctors at the clinic are crazy.

Power leveling: A paternalistic style of interaction causes distance. The clinician asserts she knows best.

This interaction prevented negotiating treatment strategies. Conversation between the family and the clinician is shut down, and the family said that they had no more questions.

Lessons Learned

Family–clinician interactions fell into categories:

(i) Partnership supported: This type of interaction occurred when communication was good, information exchange was reciprocal, and trust and respect were demonstrated. Power dynamics were balanced.

(ii) Partnership missed: This type included interactions where there was an opportunity to extend communication, trust, and respect, and the opportunity was missed.

(iii) Partnership hindered: This type happened when communication barriers existed, the patient's/family's input was not elicited, and mutual understanding and treatment agreement were not established.

Hot Cheetos may be viewed as a contrast with Smoking Coat. In both interactions, clinicians are presented with a behavioral practice (smoking, eating food triggering acid reflux) that interferes with chronic illness management. In Smoking Coat, good communication, respect, and trust are preserved, leading to a more positive discussion of asthma management. Unlike Smoking Coat in the Hot Cheetos vignette conditions were not fostered to encourage information sharing about disease management and participation in cocreating an action plan. The clinician asserted power and expressed disapproval of patient's choices.

This case highlights the complexity of pediatric care. Clinicians must attend to family with major responsibility for decisions and care and to the child who is learning health management. In the Are We Crazy interaction, attempting to understand what it means for the patient and the family to live with a long-term condition rather than focusing exclusively on the medications would have been valuable. Better acknowledging the consequences of addressing lifestyle changes could contribute to collaboration and building partnership.

Clinicians must become more self-aware and sensitive to the family's psychosocial and cultural contexts and their own biases and responses. In the Hot Cheetos and Are We Crazy vignettes, some challenges of working with adolescents are evident. For a good outcome, the clinician and the patient would need to understand each other's viewpoints and what drives their choices. Keeping in mind that all of these interactions have interpersonal and cross-cultural elements, clinicians must be more skilled in their abilities to establish a good interpersonal relationship to elicit concerns, feelings, expectations, and needs. Developing these skills is a key ongoing process.

Conclusion

Building family–clinician partnership requires mutual investment. Even the best clinicians miss opportunities or say things hindering communication. Patients and families also miss opportunities. Additionally, longstanding problems in achieving asthma care partnership pose the questions: Are partnership elements identified in the literature taught effectively in our educational institutions? What training methods can ensure that mastery of skills is tightly connected to care delivery? And how can we help families participate effectively? Knowledge of the social behavioral dynamics of care can assist in the development of evidence-based interventions to better support partnership. These complex processes need further research, education, and refinement.

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References

1. Cohen SY, Wamboldt FS. The parent-physician relationship in pediatric asthma care. J Pediatr Psychol. 2000;25(2):69-77.
2. Lung NH, Institute B. National asthma education and prevention program. Expert panel report. 2007;3.
3. Holman H, Lorig K. Patients as partners in managing chronic disease. Partnership is a prerequisite for effective and efficient health care. BMJ. 2000;320(7234):526-27.
4. Alexander JA, Hearld LR, Mittler JN, Harvey J. Patient-physician role relationships and patient activation among individuals with chronic illness. Health Serv Res. 2012;47(3 pt 1):1201-23.
5. Safran DG, Taira DA, Rogers WH, Kosinski M, Ware JE, Tarlov AR. Linking primary care performance to outcomes of care. J Fam Pract. 1998;47(3):213-20.
6. Little P, Everitt H, Williamson I, et al. Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations. BMJ. 2001; 323(7318):908-11.
7. Osborne H. The value of partnering with patients. Patient Care Manag. 2002b;17(6):7-8.
8. Bosch-Capblanch X, Abba K, Prictor M, Garner P. Contracts between patients and healthcare practitioners for improving patients' adherence to treatment, prevention and health promotion activities. Cochrane Database Syst Rev. 2007(2):CD004808.
9. Makoul G. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. Acad Med. 2001;76(4):390-93.
10. Beach MC, Saha S, Cooper LA, Fund C. The role and relationship of cultural competence and patient-centeredness in health care quality. New York, NY: Commonwealth Fund; 2006.

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Georgia Michalopoulou, PhD, is an associate professor of Psychiatry and Behavioral Neurosciences at Wayne State University School of Medicine. Her scholarly work has focused on the investigation of health care disparities, clinician's cultural competency and the delivery of patient centered care with the goal of developing models and interventions to improve patient care and to train future clinicians.

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Kaitlin C. Muklewicz, MA, received her degree from Wayne State University where she studied applied medical anthropology. Kaitlin is interested in family medicine and she is currently attending a Physician's Assistant Program at the University of Tennessee Health Science Center.

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Beverly Crider is the parent of a young woman who has multiple, significant health concerns. She is a pioneer in Parent Advocacy, and an expert in patient and family-centered care. Beverly has successfully implemented patient and family engagement strategies in public policy, managed care arrangements and in both hospital and clinic settings as the Director of Patient and Family-Centered Care at the Children's Hospital of Michigan. Beverly is the President of Patient & Family Partnerships, Inc.

Julia Wasiluk, MA, is an elementary school teacher and reading specialist. She serves as a parent advisor at Children's Hospital of Michigan and she is a member of the Children's Hospital of Michigan Advisory Council and Ethics committee. As a parent of a child with a chronic illness, Julia has a deep understanding of health care systems and a wealth of experience with health care delivery. She disseminates her knowledge by hosting an in-home training program for pediatric residents and by advising families who manage chronic conditions.