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Shared decision making in tinnitus care: an exploration of clinical encounters

Objectives: This paper examined clinical encounters between clinicians and patients to determine current practice for the diagnosis and treatment of tinnitus. The objective was to develop an understanding of the ideal clinical encounter that would facilitate genuine shared decision making.

Design: Video-ethnography was used to examine clinical encounters for the diagnosis and treatment of tinnitus.

Methods: Clinical encounters were video-recorded. Patients were interviewed individually following their clinic appointment. Data were analysed using constant comparison techniques from Grounded Theory. Initial inductive analyses were then considered against theoretical conceptualizations of the clinician-patient relationship and of the clinical encounter.

Results: Alignment between clinician and patient was found to be essential to a collaborative consultation and to shared decision making. Clinician groups demonstrated variation in behaviour in the encounter; some asked closed questions and directed the majority of the consultation; others asked open questions and allowed patients to lead the consultation.

Conclusions: A shift away from aetiology and physiological tests is needed so that tinnitus is managed as a persistent unexplained set of symptoms. This uncertainty is challenging for the medical professionals; lessons could be learned from the use of therapeutic skills. Further research is required to test techniques, such as the use of decision aids, to determine how we might create the ideal clinical encounter.

Keywords: tinnitus; hearing therapy; shared decision-making; concordance; lifeworld

Introduction

In this paper, we explore the phenomenon of shared decision making for tinnitus care through the observation and analysis of clinical encounters between people living with tinnitus and clinicians who provide diagnostic and treatment services for tinnitus. Tinnitus is a persistent hearing condition in which sound is heard in the absence of an external source. Current approaches to managing tinnitus vary depending on clinical site (Hoare & Hall, 2011). In most instances tinnitus does not have a straightforward

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medical cause. Whilst rare cases may have a clear medical or surgical solution, most people who seek help for tinnitus will not be offered a simple cure. Therefore, tinnitus care is challenging to traditional biomedical encounters because the process of diagnosis may not lead to a defined treatment. In these cases, treatment is geared to living better with the tinnitus rather than eradicating it. Clinicians are required to consider not only what the tinnitus sounds like but more importantly, what it means for the affected individual. This requires a careful and skilled approach to eliciting a patient's current behaviour, coping and preferences for both outcomes and treatment approaches.

Explicit discussion of therapeutic options is a central part of shared decision making. Elywn has noted the importance of different phases of discussion to inform choice of intervention, weighing up pros and cons of different options and relating those pros and cons to individual preferences, values and lifestyle (Elwyn et al., 2012). The term *concordance* is used to describe an agreed plan between clinician and patient and replaces terms such as 'adherence' or 'compliance' with their connotations of authority led care (Elwyn et al., 2003). These discussions rely on rapport and trust in the clinical relationship. A previous analysis of the content of audiologist-patient interactions during audiological rehabilitation consultations used conversation analysis to examine turn taking and appointment focus. This revealed that audiologists asked 97% of the questions in the encounter and shaped communication with closed questions which did not facilitate a discussion on the wider aspects of living with hearing difficulties. It was noted that there was a particularly poor attention to the emotional content of interactions (Grenness et al., 2015).

Relationships between clinicians and patients with persistent symptoms, such as tinnitus, are notoriously challenging. Such patients have been referred to as 'heart-sink' patients and confound the clinical scripts that are part of the biomedical approach to

illness (Stone, 2014). Without a clear physiological basis, it is difficult to target a therapeutic approach. This leads to challenges in communicating ambiguity about causal features and certainty about predicted outcomes (Morton et al., 2017; Salmon, 2007; Stone, 2014). Within hearing healthcare this has been documented in descriptions of patient help-seeking and coping in King-Kopetzky syndrome (Pryce & Wainwright, 2008). Similarly tinnitus has been considered a medically unexplained condition (Price & Okai, 2016; Bakal et al., 2006; Ullas et al., 2013). In tinnitus care patients are referred to a variety of hearing clinicians including audiologists, physicians and hearing therapists, yet the actions involved in the clinical help-seeking encounter in tinnitus remain under researched.

This project forms a part of a wider study about shared decision making between patients with tinnitus and healthcare professionals. Our overarching aim was to capture patient preferences, observe current clinical practices in decision making and use this information to design a decision aid for patients to select treatments for their tinnitus based on values, preferences and information needs of the patients. The patient group of interest are those seeking help with their tinnitus.

This part of the project aimed to capture how clinical decisions are made, through the direct verbal communication, through the nonverbal communication, and through indirect communication between patients and clinicians in the clinical encounter. This work contributes new insights into clinical behaviours and communication patterns in a range of clinical settings and disciplines. In keeping with the qualitative approach, patients' accounts have been prioritized. We do not propose generalizable assertions, but through systematic qualitative methods, we present an evidence-based theoretical description of shared decision making.

Method

Participants

Ethical approval was granted from NAME OF COMMITTEE HERE and sponsorship provided by NAME OF UNIVERSITY HERE to recruit people living with tinnitus and clinicians providing them with diagnostic and treatment care. Informed consent was gained to video-record and observe the clinical encounters in which they took part. Patients with tinnitus also gave consent to be individually interviewed. Recruitment took place via administrative staff at clinics providing these services.

We approached and recruited clinicians from three contrasting clinical services for people with tinnitus in England. In each service, we observed the professional group who present choices for tinnitus treatment to patients. These professionals were responsible for determining therapeutic or treatment options, presenting these to patients and planning interventions with them.

- Service A comprises audio-vestibular physicians as the primary clinical provider.
- Service B comprises audiologists or hearing therapists as the primary clinical provider.
- Service C comprises hearing therapists as the primary clinical provider.

These three clinical services operate in contrasting settings of rural, semi-rural and urban populations. In keeping with UK pathways, patients attending these services have encountered General Practitioners and some have seen Otolarynogists prior to these appointments. While both those medical groups are concerned with detecting medical problems, neither are dedicated to remediating the tinnitus complaint. In each case, the encounters that are the focus of our investigation were the first to *treat* the tinnitus. Our

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focus therefore was on the professional groups that represent that first dedicated treatment support for tinnitus for these patients seeking help. In each case the remit for the professional included diagnostic and treatment activities. All clinicians roles included checking for signs of underlying disease process, establish clear aims for each individual patient, informing each patient, and collaborating on treatment decisions, including onward referral, where needed.

Video ethnography

First and second clinical appointments were videoed using a video camera set up in clinic rooms. The observations followed procedures of ethnography: researchers were familiarised with the settings, observed sessions, and used the video camera as a 'fly on the wall' to gain naturalistic data. Our aim was to observe clinical encounters in as natural a way as possible. A coding frame was set up to code the data, following the logic of the constant comparison technique from Grounded Theory (e.g. Strauss & Corbin, 1990). This approach used data to derive initial themes rather than to check previously established theory. A range of clinicians and locations were sampled from to ensure maximum variation in the data in both clinicians and patients.

Four researchers (INITIALS HERE) watched videos and summarised content features e.g. topics discussed and structure of encounter. Videos were viewed repeatedly to examine content and define 'units of analysis'. In this case units of analysis were the meaning themes identified repeatedly in the video excerpts. The researchers (INITIALS HERE) were both clinicians and researchers who could apply topic specific knowledge to the context and content of the observations. None of the researchers were participating clinicians but there were clinical colleagues among them. The supervising researchers, a Health Psychologist and Hearing Therapist (INITIALS HERE), were external to the clinical settings and applied theoretical models to the data. Keywords

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and phrases used were noted and used to form codes to summarise meanings within the data. In addition, non-verbal behaviours were observed to communicate meanings, including attentiveness, engagement and responsiveness of the clinician and the patient to each other's non-verbal communication e.g. mirroring postures.

These meanings were constantly compared across the data set and were refined as new examples of variations on themes were identified. Finally, a refined set of key themes were applied to new data in an iterative fashion to check the themes covered all aspects of meaning and content within the observations. Such approaches to data analysis are informed by Hammersley and Atkinson (1995).

The researchers triangulated their observations by firstly observing and noting key themes individually and then by presenting themes and variations to the themes to each other and refining their labelling. The final set of themes were agreed by the wider research team (INITIALS HERE).

Individual patient interviews

Forty one face to face interviews were conducted at patient homes, lasting approximately one hour each. During these interviews patients described their preferences for the range of interventions and sources of help and support with tinnitus. Patients were asked to describe the role of clinical encounters in shaping their interpretations of their tinnitus. They were asked to comment on what was helpful and unhelpful in clinical encounters. Interviews were conducted by the researchers in each location (INITIALS HERE) and the process of collating themes and building theory were supervised by the senior researchers (INITIALS HERE). Interviews were audio-recorded, transcribed by a transcription service and analysed using the constant comparison technique from Grounded Theory (Strauss & Corbin, 1990). To achieve this, the researchers independently coded the data, and then meetings were held together

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with senior researchers (INITIALS HERE) to discuss and agree the themes presented. In this case, NVivo was used to conduct initial coding and to collate codes across accounts. Further extraction of codes focussed on help-seeking and the clinician-patient relationship. The findings from the interview data will be reported fully elsewhere (Pryce et al., 2017, under review).

Synthesizing the analysis

As this was the first examination of this kind of clinician-patient interactions in help-seeking for tinnitus an approach relying on inductive and deductive thematic development was chosen to syntheses the analyses of consultations and interviews. Following the parallel inductive analyses of each data set, codes were compared against each other and synthesized into a set of themes which represent the whole corpus. Descriptions of phases of activity within the encounters from the videos and their meanings were compared with interview data representing the meanings attributed to these encounters by patients. For example: observations of information exchange between the clinician and patient were compared with accounts of the process of information exchange. This comparison was of broad themes and messages across the data sets, rather than individual accounts and videos.

Following the inductive data analysis, we explored existing theorizations of the kinds of activities observed in the encounters and of conceptualizations of the clinician-patient relationship. In particular, we examined our data alongside the theoretical construct of *concordance* (Elwyn, et al., 1999; Elwyn et al., 2003), the changing nature of the *doctor-patient relationship* (Wirtz et al., 2006) and to Habermas' theory (1986) of communicative action, as applied medical encounters by Walseth & Schei (2001), which proposes a multifaceted *lifeworld approach* to care. Each of these theorizations of clinical encounters critiques the 'tradition' of a paternalistic clinician dominating the

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consultation with medical language and imposing recommendations onto a passive

patient in comparison to an autonomous patient who is actively involved in shared

decision making and who directs the consultation toward a treatment decision which fits

their lifeworld.

Results

 We video-recorded clinical encounters between six clinicians and thirteen

patients. The clinician participants included hearing therapists, audiologists and audio-

vestibular physicians (AVPs). Table 1 describes the characteristics of the patient

participants.

 [Table 1 here]

 Our patient participants included seven men and six women with ages ranging

from 20s to 70s. Of the observed patients, none had any medically treatable cause to the

tinnitus identified. Eight participants had identified hearing loss which formed part of

the discussion. Due to the small pool from which clinicians were drawn, no further

details are provided in order to protect their anonymity. A summary of example

excerpts and the themes that were used to summarise and build theory are presented in

Table 2.

 [Table 2 Here]

 We will present the findings from the synthesized analysis of video and

interview data following a description of the encounters. Sections from the video-

recordings are described; in places, verbatim extracts are included from interviews.

The content of the clinical encounter

 Each consultation observed included an introduction to what would happen in

the consultation, obtaining case history, gathering clinical details and descriptions of the

symptoms, a discussion about what potential causes there may be and a plan of next steps to tinnitus management.

The observed encounters ranged in length from 25-70 minutes. There was a notable variation in time allocated to clinician talking versus patient talking across the encounters recorded. These ranged from clinicians being observed to speak for 95% of the time and their patients for 5% to those where the clinician spoke for 55% of the time and the patient spoke for 45% of the time. The other key difference observed was that the history taking phase of the encounter varied according to the time the patient was speaking from 10-25 minutes; in other words, how long was spent listening to the patient describing their experience.

[Figure 1 around here]

Notwithstanding these variations, each clinician did invite patients to describe their experiences of symptoms of tinnitus and to consider health related factors which may affect it. A preliminary explanation was applied, either toward potential causes for the tinnitus symptoms or a less specific explanation about what tends to influence tinnitus symptoms. Finally, all encounters concluded with a plan of either further diagnostic investigation or of therapeutic treatment. The diagnostic plans included MRI scans, CT scans, hearing tests and blood tests. The therapeutic options included management strategies for thinking about the tinnitus, hearing aids or use of environmental sounds. The link between treatments suggested and assessment or case history findings were not always clear and reflect the previously documented difficulties in using clinical markers to predict treatment effect (Hoare & Hall 2011).

Alignment within the clinical encounter

The talking-listening behaviours, suggestions of treatments, and summations of medical history formed a key feature in the encounters and represented different points

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along a continuum of what we conceptualize as 'alignment'. This concept of alignment represents the perfect balance in the encounters between clinician- and patient-led content and talk. That perfect balance would involve *responsiveness* on the part of the clinician who is *attending* closely to the patient's experience of living with tinnitus. Thus, alignment provides a meaningful framework for assessing the responsiveness of the clinician to the patient-led content and the degree of collaboration that exists between clinician and patient. Alignment refers to the parts of the encounter where the patient and clinician are equally engaged in the topic being discussed. Attending is illustrated by verbal and non-verbal behaviours including responsive posture, verbal and non-verbal prompts, attention, and mirroring postures.

[Figure 2 around here]

Within the concept of alignment there was a range of points of variance which altered the way meanings were communicated. Information exchange varied between clinicians extracting key information from patients and information being volunteered by the patient. In encounters with greater alignment between clinician and patient, information was elicited rather than asked for directly. The clinicians used non-verbal and verbal prompts to open up discussion and follow the emphasis placed by the patient, rather than adhering to a preconceived script. For example, when a patient began the interaction with a description of other health problems the clinician listened attentively to these before asking how they impacted tinnitus.

Responsiveness and attending through communication

The tone of the encounters varied despite a consistent pattern of content. The main variation in tone was associated with the professional group and service structure. The audiologists used a clinical case history questionnaire to structure their encounters. The hearing therapists used the same questionnaire, but more as a topic guide rather

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than a set of closed questions. This variation influenced the amount of time the clinician was directing the encounter and the amount of time the patient led the content of the encounter. Variations were observed in the effect of these behaviours on closing down communication or broadening out the content of the interaction.

A typical opener involving closed content was: "*tell me when the tinnitus started?*", followed up with further closed questions, "*did it start gradually or suddenly?*". Closed questions indirectly communicate a value to these details and set up the encounter within a hierarchy of knowledge, i.e. as if there is a 'right' answer. The patient role here was to comply and answer questions as directed.

In contrast, an opening question that was exploratory, enabling the patient to direct the content when taking a case history beginning with *"tell me about…"*. In this case, the clinician formed a different sort of relationship with the patient and rapport was built by focussing on the patient's perspective on the situation, symptoms and priorities. Patient preferences for outcomes and treatment were elicited through open questions which help patients consider their tinnitus within the context of their life as a whole, e.g. "*so how do you feel you deal with that?*"

Responsiveness and attending through power

A central indicator of alignment was the expression of authority and power within encounters. The manifestation of authority ranged from the traditional patriarchal relationship with the clinician occupying the powerful, knowledgeable and authoritative role to relationships demonstrating the positioning of the patient as an autonomous decision maker (Wertz, Crib & Barber, 2006). The demonstration of authority would begin the interaction by establishing their professional role and focus of interest in the encounter.

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> "I'm Dr *X* and we've got a letter from your GP saying that you've been suffering
> from noises in the ears. So how long has it been going on?"

The authority of the professional was communicated further by descriptions of testing procedures. Here the importance of a hearing test is not made clear, nor what is involved in undertaking one.

> "I'm afraid we're going to have to have another hearing test today so we can
> compare with the previous one and then we will continue after your test."

No opportunity to decline the test or ask why it is being taken was offered here. Further examples of diagnostic procedures were present : "*so I'll organise the MRI and the CT scan and ask the GP to send me a copy*". The background or detail of the procedures was not described. This communicates an unchallenged value on physiological signs and implies the possibility of medically relieving the symptoms. However, evidence on tinnitus treatment suggests that this is unlikely to be the case (Hoare & Hall, 2011). Such tests are framed in this encounter as routine.

By performing diagnosis in this way, the clinician is validating the symptoms and providing a medically sanctioned interpretation of this subjective experience. For some people though, this assertion of medical knowledge and authority was a comforting part of the clinical encounter. This level of scrutiny of bodily signs was perceived as thoroughness in care and met some patients' expectations of a clinical encounter. Following a series of tests, one patient was satisfied that the clinician was doing all s/he could and thus was happy for the treatment decision to be made for her.

> Okay, right, we're going to go and do another test for this and then we're going to
> do another test here and another test there. It felt like [s/he] wanted a whole picture,
> which was what I wanted: to feel like someone had taken an interest and was trying
> to sort it out; rather than just doing one test and saying right, okay, yeah, it looks
> like this; we're going to refer you to here. [..] And that's what you're fighting for, is

to get to that specialist. [..] So she answered every issue that I had. So, I was happy with the decisions that [s/he] was making for me.

In establishing an importance to biomedical signs the clinician was reinforcing their authority as the person in the encounter with knowledge and expertise to provide an interpretation of the 'truth' about the tinnitus symptoms. The risk of a clinician-led encounter (Williams et al., 1998) is the potential to misdiagnose and misunderstand or simply bypass patient preferences in treatment (Mulley et al., 2012). In contrast, some patient participants reported dual preferences for outcome, both to remove the symptoms and to learn to manage them better.

Some clinicians were observed to focus their gathering of a case history using a series of closed questions designed to summarise the perception of the tinnitus, rather than the management of the tinnitus:

"Did it start gradually or slowly?"
"Did anything trigger it?"
"Does it affect your sleep?"
"Can you continue with sports?"

These questions elicit some factual details and clarification was sought when they were not precise, "*so is that 5 months ago?*". The tone of the clinician and patient differed at this point. The clinician asked, "*is it there all the time or is it intermittent?*" and the patient answered with a description of experience, not the category offered, "*I'm pretty sure it's there all the time, but if I'm doing something, I might not hear it*". The direction of the questions asked signifies a focus on aetiology, which in turn suggests that a particular course of treatment for that particular cause may 'cure' the tinnitus.

By contrast, those clinicians with counselling and therapeutic skills differed in the way that questions were used. For example, in establishing the timeline, the therapist followed the emphasis placed on the experience by the patient:

Patient: What I understand now to be tinnitus, I've probably had for a long time. But it only became very noticeable in May of this year

Clinician: Ok so something happened in May this year?

Patient: Something turned up the feedback and now I've got a whine on top of the whooshing

Clinician: Ok, and how does the tinnitus affect you? So, the new noise, something shifted in May and how are you dealing with it?

Patient: Initially I was pretty stressed

This example illustrates a greater alignment between the clinician and patient resulting from the responsiveness of the clinician. The clinician has allowed the patient to lead the content of the encounter which enabled coping to become the focus, e.g. *"from the point of view of your tinnitus, where would you like to go?"*.

The significance of the interactions with clinicians becomes clear when considering the long journey some patients have travelled before receiving a diagnosis or any support with making decisions about treatment:

"I had my ears done and I went to the audio clinic in [location], and they said, "It is tinnitus, it's not blocked or anything," and send me to a consultant because what they wanted to do was to explain that there could have been fluid or something in the ear and it could be dangerous, he said, "But looking at you, I don't think there's anything to worry about, I'm 99.9% sure, but to be absolutely sure I'm going to send you for a scan – an ear scan." So they sent me for an ear scan and it came back okay of course. Then I went and saw [the therapist] so really that's a potted history of it."

The lengthy diagnosis process is related to the multi-profession approach to tinnitus care and differences between services offered around the country. The

medicalization of physiology observed in consultations with some clinicians represents the 'traditional' patriarchal approach to care which prioritizes and demands specialist medical knowledge. It is in direct conflict with the notion that tinnitus is a persistent unexplained symptom and essentially a subjective experience. The responsive approach of therapeutically orientated clinicians showed a good degree of alignment and attendance to the lifeworld of patients so that real-world matters were included in the consultations.

Making or offering decisions about treatment

Decision making for treatment varied from being clinician-led to shared between the clinician and the patient. For example, some observed encounters featured clearly prescribed treatment. In this example, a hearing aid is offered without alternative. The quality of the patient's hearing was not clearly described and there was no sense of why a hearing is necessary or indeed how it will help:

> Clinician: But your hearing's not too bad
> Patient: Good
> Clinician: With a hearing aid, you'd do fine

Another example shows a clinician considering and then rejecting a referral to a therapy service for support adjusting to their tinnitus without consulting them: "*now it doesn't sound to me like you'll need hearing therapy*". In these cases, the decision making was held by the clinician and was not shared with the patient. In contrast, other clinicians offered choices and negotiated treatment options with patients:

> Clinician: I wonder whether we should go through choices of management [..]
>   It's entirely up to you whether we go for the hearing aid or other
>   strategies to help your hearing and communication first.
> Patient: I'd rather do that first.

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Clinician: Right, ok.

In this theme, we saw examples of Elwyn's notion of concordance in action. Negotiation was employed which offered patients the opportunity to make a choice about treatment based on the options given. However, the degree to which these decisions were informed is questionable because there were few examples when clinicians described in detail the advantages and disadvantages of different treatment options.

Creating the ideal consultation

The variations in clinician behaviour observed ranged from the 'traditional' biomedical approach of the paternalistic clinician to the empathic relational approach which signified that alignment was required for concordance to occur and for decision making to be truly shared. These differences reflect alternative philosophies of healthcare more broadly, but also for tinnitus specifically. Habermas (1986) described the challenges of integrating different realities into clinical interactions. Our data has confirmed that these difficulties still persist. In particular, he described the concept of the *lifeworld* which encompasses the whole of our existence, our everyday experiences, our relationships, our geography, history, socio-economic status, etc. and many other factors which influence our meaning-making processes. Walseth & Schei's (2011) application of Habermas' ideas sets out a framework for the ideal consultation, proposing the appropriate content of a clinical encounter, what should be said and how it should be said. Within this framework, lifeworld is comprised of an *objective world* with empirical, factual medical knowledge; a *social world* comprised of the rules and norms of a social group; and a *subjective world* comprised of intentions, beliefs and emotions (Walseth & Schei, 2011). Our data describe how these 'worlds' are

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incorporated into a clinical encounter for tinnitus. Table 3 provides a summary of the encounters observed in respect of the 'worlds' represented by the approaches taken by the different clinician groups.

[Table 3 here]

By conceptualizing the encounters observed through the lens of a lifeworld-led approach to care we have learned that prioritizing one world, e.g. the objective world of physiological medicine, does not satisfy the requirements for a consultation about a condition with no identifiable medical aetiology. Likewise, an encounter focussed purely on the subjective world which denied the need for any course of treatment or techniques to self-manage tinnitus would not satisfy the needs of the patient. It is only through the interaction of these three worlds that the lifeworld of patients can direct decision making. The ideal consultation, therefore, might be described as:

> "*an open space* where patients are offered accessible information and time for consideration; an opportunity for [clinicians] to determine *what matters to patients within their life context* when making a treatment decision; a *collaborative consideration of options* taking into account the evidence base and what is right for the patient; and a *two-way dialogue* where [clinicians] adopt *academic humility* and patients feel genuinely confident to make an informed decision that is right for them." (Borg-Xuereb, Shaw & Lane, 2015: 449)

To achieve this ideal, the clinician needs to work as a facilitator, guiding patients through appropriate options according to what will fit their lifeworld. This requires skilled communication which places the patient at the centre of the encounter. Furthermore, as we found in this study, a sense of alignment between the patient and the clinician is critical to reaching a truly shared decision.

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Discussion

Our findings support contemporary models of clinician-patient relationships in which clinicians occupy roles as either experts or partners, or increasingly, as service providers (Salmon, 2000). The tensions in the role of patients in clinical encounters for tinnitus highlights the underlying challenges to the biomedical model of health and illness that tinnitus presents. By definition tinnitus is a subjective experience, mediated by a range of psychological interpretations of symptoms. Yet these observations demonstrate that some clinical services are still organised around the patients as passive recipients of care, reflecting the continued presence of the clinical gaze in contemporary healthcare (Wainwright et al. 2006). This emphasis conforms to the biomedical script but is not in alignment with patient preferences for information and coping advice. If emphasis during encounters is on aetiology and the discovery of new signs or symptoms, it is not placing sufficient emphasis on the coping and living management of existing symptoms. At worst, this perpetuates a myth that tinnitus is only a symptom of an underlying medical condition (or physiological problem) and that once the underlying condition is treated it will be removed as a symptom.

Alignment was the key theme that emerged from the inductive data analysis and this defines the quality of the relationship between clinicians and patients. The concept here refers to the quality of the relationship and suggests concordance in decision making. In addition, it highlights the importance of attention to what Habermas has described as the subjective world and corroborates the findings of Grenness that audiologists' attention to emotional content (a key part of attending to the patient's 'subjective world') is lacking (Grenness et al., 2011).

The talk around the treatment process is much less clearly defined in encounters with audiologists and doctors than with hearing therapists and highlights the skills

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required to engage patients in complex conversations about management (Elwyn et al., 1999). Hearing therapists were seen to engage more fully in active listening, which has been recognised as a key communication skill when working with people with persistent conditions (Lang et al., 2000). These skills are important as empathetic behaviours and in particular communication behaviours that encourage patients to express themselves enhance patient satisfaction in the relationship (Williams et al., 1998).

Salmon notes that people with medically unexplained conditions seek help to form an alliance with the clinician against the disease entity (Salmon, 2000). These data confirm this view with an emphasis on patients seeking support rather than removal of the tinnitus.

Limitations and recommendations for future research

The study reported has good coverage in terms of the make-up of clinics which offer services for tinnitus diagnosis and treatment. However, given the focus in some encounters on aetiology and the conduct of tests to identify potential underlying physical causes of tinnitus, it could be useful to repeat the study with otolaryngologists, ear, nose and throat (ENT) specialist physicians, who surgically manage patients with ENT diseases and disorders. A repeated study would require additional efforts in the recruitment of clinicians. Recruitment of clinicians was challenging, particularly because of the video-recording of the consultations. Patients, on the other hand, were very happy to take part. The presence of the video camera could have influenced the behaviour of clinicians leading them to exaggerate features of their practice. However, we did witness a wide variety of behaviours and emphases in practice, possibly because of the contrasting range of clinicians involved in the study. Patient participants reported being unconcerned by the presence of the camera. Ethnic diversity was good, but of

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course further work with minority ethnic groups and with those whose first language is not English would further aid our understanding of how to create the appropriate structures in which the ideal encounter would flourish.

Our findings suggest a change in the approach to clinical encounters for tinnitus is needed; learning could be taken from the counselling skills observed among hearing therapists. Further research is required to identify techniques that would facilitate a collaborative consultation style and produce decisions about treatment informed by the patient's lifeworld. One such possibility is the use of decision aids to help direct the conversation about potential treatments and to enable the clinician and patient to work together to make an informed and appropriate decision.

Conclusion

Findings suggest a shift in focus is required to move away from the current prioritization of the biomedical treatment of tinnitus. Running tests for aetiological purposes is safe territory for clinicians, but their function is to maintain the myth that there is a biological cause that can be fixed. The clinicians with counselling and communication training, on the other hand, were able to deal with the uncertainty presented by the persistent symptoms of tinnitus. Instead of adopting the powerful position of medical expert, they were able to consider the management of tinnitus within the life context of the patient. Finally, to achieve concordance within a clinical encounter, and for shared decision making to become a reality, there needs to be alignment between clinician and patient.

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Figure 1: The content of the clinical encounter

Introduction to appointment and case history (approx 10-15 minutes or 22-33% of appointment)

Explanation, information giving (approx 30 minutes or 50-65% of appointment)

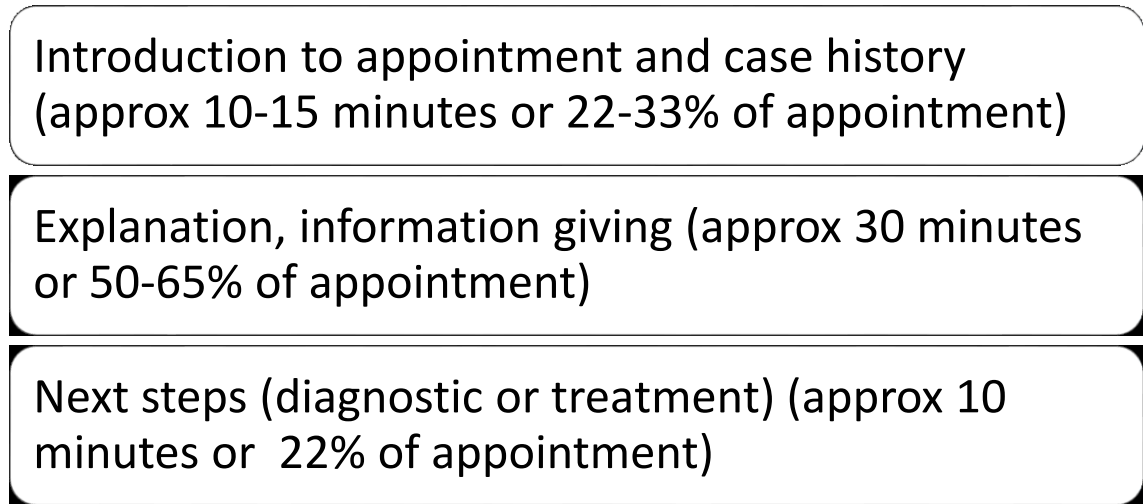Next steps (diagnostic or treatment) (approx 10 minutes or 22% of appointment)

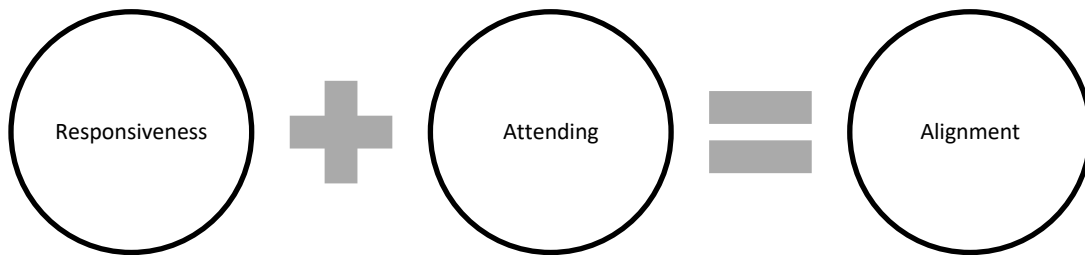Figure 2: Alignment split into two components: responsiveness and attending.

Table 1: Descriptive characteristics of patient participants including presence or absence of hearing loss & additional clinical contacts

Sex	Age range	Hearing loss?	Postcode descriptor*	GP	Otolaryngologist
M	50s	no	MH	Yes	Yes
F	50s	yes	OO	Yes	Yes
F	50s	no	MH	Yes	Yes
M	60s	yes	OO	Yes	No
F	80s	Yes	OO	Yes	No
M	60s	no	OO	Yes	No
M	50s	Yes	OO	Yes	Yes
F	50s	Yes	MH	Yes	Yes
M	40s	Yes	OO	Yes	Yes
F	50s	Yes	MH	Yes	Yes
M	20s	No	MH	Yes	No
M	40s	No	OO	Yes	No
F	40s	Yes	OO	Yes	No

*Postcode descriptors to describe nature of local community

MH: Mixed housing districts (private rental, social housing etc.)

OO: Live in owner occupier neighbourhoods

Table 2: Example of themes applied to video observation

Example video transcript description	Video analysis theme	Dimensions to theme	Proposed through observation by	Confirmed through observation by
'I'll explain how we hear'	Information giving	Tailored >Generic	Researcher INITIALS HERE	Research management group INITIALS HERE
'Did it start suddenly or gradually?' 'Tell me how you're getting on with your tinnitus'	History taking	Patient giving a history or having a history taken	INITIALS	INITIALS
'I'll explain to you in a moment…' 'My name is Dr…' 'I'm here to talk to you about your tinnitus'	Authority	Signifiers of authority	INITIALS	
'just listen to the tinnitus and control your reaction to the tinnitus' 'if you become more positive over time your perception will change' 'it doesn't sound to me like you need a hearing aid'	Options	Hearing aids, sound, maskers, cognitive strategies, groups	INITIALS	
'I think, if you become more positive, your perception can improve'	Decision	Structured > not structured	INITIALS	
	Who's talking	Patient led or clinician led	Proportion timed in video review	

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Table 3: Tinnitus care and the lifeworld of the patient in the encounter

Objective world	*Social world*	*Subjective world*
Clinicians prescribe medical investigations to illuminate pathologies.	In all encounters clinicians lead the structure and timing of the encounter.	Clinicians engage with emotional content, patient priorities and subjective experience.
Clinicians enquire about precise detail of symptoms start.	All encounters are structured around an exploration of tinnitus symptoms and a direction towards activities to either diagnose potential problems or to provide relief for the symptoms.	Clinicians ask questions to elicit subjective world experience e.g. 'how do you feel about that?'
Clinicians do not focus on detail of symptoms but rather attend to impact of symptoms as priority.		Clinicians do not invite subjective world experience into the encounter.