

Congestive Heart Failure Patients Report Conflict With Their Physicians

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Background: Given the importance of the doctor-patient relationship, we examined the prevalence and nature of patients' perceived conflicts with the physicians caring for their congestive heart failure (CHF). **Methods and Results:** This cross-sectional study recruited patients with CHF in the outpatient and inpatient service of a tertiary referral hospital. Patients completed demographics, semistructured interviews, and surveys of emotional and health status. CHF physiologic measures and comorbidities were abstracted from the medical record. A team of 2 blinded coders analyzed the interviews. Thirty-one percent of the 289 patients reported difficulties with physicians. In the bivariate analysis, only marital status was significantly associated with conflict. Major problems included the providers' poor communication skills (20%), trust in the physicians' competence (18%), and insufficient medical information (16%). Patients identified care outside the tertiary referral hospital (13%) and inadequate communication between physicians (9%) as additional sources of difficulty.

Conclusion: Perceived conflict with providers is common in patients with CHF. Patient-level factors, however, did not predict conflict, which differs from our previous findings with hepatitis C patients. Perceived conflict is troubling because it can undermine the trust in the doctor-patient relationship, thereby weakening the therapeutic bond necessary to care for this sick and often vulnerable population.

Key Words: Congestive heart failure, Doctor-patient relationship, Communication.

Congestive heart failure (CHF) affects 4.8 million people in the United States and is the chief cause of hospitalization among the elderly,¹ resulting in \$38.1 billion in annual health care expenditures.² With a prognosis worse than many cancers, CHF is a leading cause of mortality in the United States, contributing to an estimated 300,000 deaths each year.³ Cases of CHF have increased 5-fold in the last

10 years,³ resulting in what the National Institute of Heart Lung and Blood described as a "new epidemic."⁴ Given the high prevalence of the disease and its unpredictable trajectory, open communication between patients and health care providers is essential. This includes discussions of disease prognosis, resuscitation preferences, and treatment strategies.⁵⁻⁸ Considering the often-subtle signs of worsening health, patients need to trust their physicians and feel comfortable discussing such matters.^{9,10} An effective doctor-patient relationship has been associated with an increase in patient satisfaction,¹¹ adherence to treatment recommendations,¹² lower hospital readmission,¹³ and better quality of life in patients with CHF.¹⁴ The doctor-patient relationship has been seen as especially important in the management of CHF, because physicians must be aware of worsening symptoms to adequately treat their patients.¹⁵ Despite this, few studies have examined the relationship problems CHF patients experience.¹⁶ There are no studies defining the frequency and nature of CHF patients' conflicts with providers and their relationship to demographic, psychosocial, or clinical factors. Thus, to address this, we conducted a study to determine both the prevalence and the type of conflicts that CHF patients described with providers caring for their cardiac disease.

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Methods

Patients

The methods for this analysis have been published elsewhere.¹⁷ The electronic medical record was used to identify patients diagnosed with CHF who were presenting in the heart failure outpatient clinic or the inpatient cardiology unit of a large tertiary referral teaching hospital. The protocol was approved by the university's Institutional Ethics Review Board. CHF patients who were competent to provide informed consent, older than age 18, and not prisoners were included and interviewed (*see Appendix*). If they mentioned present or past conflicts with physicians, they were asked to elaborate on the type, location, and cause of such problems. Each interview was recorded and transcribed verbatim by the interviewer.

Coding

We have described the construction of the codebook and the methods for intercoder reliability elsewhere.^{17,18} The frequency and types of conflicts were determined by using a "quasi-statistical" qualitative methodology.¹⁹ For our study, the code of interest was the expressed conflict with a physician caring for their cardiac disease. The presence of conflicts was operationally defined as a negative judgment about a physician who was charged with treating the patient's CHF and cardiovascular health at any point. The absence of conflict was operationally defined as a positive or neutral judgment about relations with CHF treating physicians (eg, "I've really loved having him," "I haven't had any troubles") with no mention of difficulties throughout the remainder of the interview.

Demographic, Survey, and Clinical Measures

Patients completed demographics (age, gender, race, marital status, and education); the Hospital Anxiety and Depression Scale (HAD), a self-assessment scale for mood disturbances in a nonpsychiatric patient population;²⁰ and the Sickness Impact Profile (SIP), a behaviorally based health status measure including subscales for physical symptoms (Body Care and Movement, Ambulation, Mobility), psychosocial difficulties (Emotional Balance, Social Interaction, Alertness Behavior, physical ability to Communicate), and physical and psychosocial summary scores.²¹ A research assistant with a medical degree abstracted from the medical record: medical comorbidities (Charlson Comorbidity Index),²² psychiatric diagnoses, and the physiologic measurements of CHF (New York Heart Association classification [NYHA], left ventricular ejection fraction, serum sodium concentration, and the serum creatinine concentration).

Statistical Evaluation

All analyses were performed using SPSS version 12.0. We first summarized the demographic and clinical characteristics of all patients in our sample. We then compared these same characteristics for those patients who described a conflict with a provider versus those who expressed no conflict, using Wilcoxon rank-sum tests, if the variables were continuous or ordinal, and either chi-square or Fisher's exact test for the categorical data. We also examined the association between conflicts with physicians and measures of health status and mood-disturbances based on the HAD and SIP questionnaires, as well as the mental and physical comorbidities and the physiologic measurements of CHF. A $P < .05$ was considered statistically significant. We also examined the percentages

of the major themes expressed by patients. All themes were coded dichotomously as present or absent.

Results

Patients Characteristics

Between October 1998 and August 2003, 413 patients diagnosed with CHF were screened for enrollment into the study. Sixty-nine patients refused to participate, mostly because of a lack of time before their scheduled clinic visit. Thirty-eight patients did not complete the interview, again largely because of time, and 17 interviews were lost because of technologic failure. These cases were excluded from the analysis, leaving a total of 289.

The patient population (Table 1) was dominantly male, white, and married, with more than half having a high

Table 1. Patient Characteristic

Variable	Number / Percentage or Mean / Standard Deviation
Patients	289
Age (years)	58.65 (SD 14.33)
Women	96 (33.2%)
Ethnic background-	
- Caucasian	263 (91.3%)
- African American	11 (3.8%)
- Other+	14 (4.9%)
Education	
- K-12	152 (52.6%)
- Some College	75 (26.0%)
- College	29 (10.0%)
- Professional Degree	33 (11.4%)
Marital status	
- Lives with partner	198 (68.5%)
- Lives alone	91 (31.5%)
Employment status	
- Employed	201 (69.5%)
- Unemployed	88 (30.4%)
Coexisting psychiatric diseases	43 (15.5%)
Charlson Comorbidity Index	1.5 (SD 1.7)
Outpatient	130 (45.0%)
Left Ventricle Ejection Fraction	34.83% (SD 16.82)
Serum Sodium	138.05 meq/l (SD 7.26)
Creatinine	1.27 mg/dl (SD 0.45)
New York Heart Association Class	
I	28 (11.7%)
II	81 (33.8%)
III	122 (50.8%)
IV	9 (3.8%)
Hospital Anxiety Depression Scale	
Anxiety score	Borderline = 50 (21.9%) Full case = 40 (17.5%)
Depression score	Borderline = 36 (15.8%) Full case = 18 (7.9%)
Sickness Impact Profile	
- Physical dimension	11.99 (SD 12.16)
- Psychosocial dimension	13.62 (SD 16.63)
- Emotional Balance	14.40 (SD 19.12)
- Body Care Management	9.02 (SD 12.98)
- Mobility	13.86 (SD 18.76)
- Social Interaction	14.46 (SD 17.72)
- Ambulation	19.85 (SD 17.63)
- Alertness Behavior	15.93 (SD 25.12)
- Communication	5.04 (SD 11.32)

+ (Includes Hispanic, Native American).

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