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The importance of patient-centered care for various patient groups

Dolf de Boer [a,b,*], Diana Delnoij [b,c], Jany Rademakers [a]

[a] NIVEL (Netherlands Institute for Health Services Research), Utrecht, The Netherlands
[b] CKZ (Centre for Consumer Experiences in Healthcare), Utrecht, The Netherlands
[c] Scientific Centre for Transformation in Care and Welfare (Tranzo), Tilburg University, Tilburg, The Netherlands

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ABSTRACT

Objectives: To assess differences in the importance ascribed to patient-centered care between various patient groups and demographic groups.
Methods: Survey data collected using questionnaires were analyzed for patients that underwent hip or knee surgery ($n = 214$), patients suffering from rheumatoid arthritis ($n = 343$), spinal disk herniation ($n = 145$), breast abnormalities ($n = 596$) or congestive heart failure ($n = 118$). A composite for patient-centered care priorities was constructed ($\alpha = 0.82$) and compared to the average importance over all healthcare aspects in the surveys.
Results: All patient groups considered patient-centered care to be of above-average importance (p's < 0.001). Small but significant differences were observed: patient-centered care was more important for patients suffering from congestive heart failure ($p < 0.001$) and patients who were younger, female, well-educated and healthier (p's < 0.05). Patients who had undergone hip or knee surgery considered patient-centered care more important than patients with spinal disk herniation did ($p < 0.05$).
Conclusion: Patient-centered care is important to all patient groups. Differential policies regarding patient-centered care for patient subgroups do not seem required.
Practical implications: Given the importance attributed to patient-centered care, it is essential that elements of patient-centered care are included in surveys, indicators of quality of care, and the training of doctors and nurses.

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1. Introduction

Patient-centered care is both a goal in itself and a tool for enhancing health outcomes [1]. For some time, it was generally assumed that patient-centered care is always superior to any other policy and more appreciated by patients as well. However, accumulating evidence suggests that not all patient groups are equally responsive to a patient-centered approach [2–6]. Given that patient-centeredness has been identified as an important priority for improvement of healthcare [7], it is important to increase our understanding of the settings and circumstances that determine the extent to which patients appreciate patient-centered care.

Before discussing empirical literature on preferences for patient-centered care, the concept itself deserves some consideration, as a variety of interpretations and operationalizations have been adopted [2,8–10]. In their classic paper entitled *'Patient-centeredness, a conceptual framework and review of the empirical literature'*, Mead and Bower distinguished five dimensions of patient-centered care [8], all of which essentially materialize within the doctor–patient relationship. These dimensions are: the bio-psychosocial perspective (i.e. the doctor also appreciates the psychological and social aspects of the health problem in addition to the biomedical aspects), the doctor as person (i.e. the doctor uses his/her own subjectivity and sensitivity as a tool to enhance the doctor–patient relationship), the patient as person (i.e. doctor is not just concerned with the disease but also attentive to the individual's personal circumstances and experience of illness), sharing power and responsibility (i.e. doctor involves the patient in decision-making and provides information to that end) and the therapeutic alliance (i.e. both a professional and personal partnership between patients and doctors that enhances the desired emotional context during consultations). It has been suggested that researchers should expressly state how they define patient-centered care. This will make systematic evaluation of the empirical literature [9] possible. We would therefore like to make clear that this study will employ a composite measure that focuses on the last three of the above-mentioned dimensions of patient-centered care. More specifically, we will address the following aspects of care as they are experienced by patients during the consultation: being listened to attentively, being able to ask

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[*] Corresponding author at: NIVEL - Netherlands Institute for Health Services Research, PO Box 1568, 3500 BN, Utrecht, The Netherlands. Tel.: +31 30 2729658.
E-mail address: d.deboer@nivel.nl (D. de Boer).

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questions, being taken seriously, receiving understandable explanations, and shared decision-making.

Although evidence looking at the extent to which patient experiences are reflected in their global ratings stresses the importance of these process aspects [11], several studies also suggest that patient-centered care is valued differently across demographic groups. It has been reported for example that patients have a higher preference for patient-centered care or elements of patient-centered care if they are female, white, younger, better educated, healthier or have a higher income [4–6]. Similarly, Swenson et al. reported that younger patients and more highly educated patients appreciate a more patient-centered communication style [12]. In addition, a review by Janssen et al. showed a number of differences between younger and older cancer patients regarding the type of information and the amount of information they require [13]. Thus, there is evidence that demographic groups differ in the extent to which they value elements of patient-centered care.

Another way to categorize patients is to look at the health problem they present with. As far as the authors are aware, quantitative comparisons between patient groups with distinct health problems focusing on preferences for patient-centered care are limited. However, a number of studies indicate that the health problem at issue also partially determines whether patients prefer patient-centered care. For example, when asked which role individuals would prefer when it comes to decision-making regarding medical treatment, cancer patients are reported to prefer a significantly less active and responsible role compared to the general public [14]. In addition, cancer patients who recently experienced a substantial worsening of their condition are less likely to appreciate involvement in decision-making [15]. This finding is consistent with the more general notion that patients are less likely to engage in decision-making as disease severity increases [16]. Also, while in a patient-centered approach patients would be given the best information possible, cancer patients with a lower life expectancy are less likely to want to discuss life expectancy [17] and have also been reported to avoid certain information in an attempt to convey hope [18]. Further, a qualitative study from our group indicated that aspects regarding the information exchange between doctors and patients were scarcely included in the ten most important preferences of breast cancer patients, but were highly prevalent among the priorities of patients who underwent cataract surgery or hip or knee surgery [19]. Finally, when rating video vignettes of hypothetical consultations, participants' preferences for a directive or a shared approach appeared partially dependent on the health problem discussed [20]. Since in the latter study, participants were presented with a hypothetical situation, it remains to be determined whether there are differences between groups of patients who are actually suffering different medical problems. Nevertheless, although fragmented, the available evidence more than justifies the hypothesis that the health problem at issue also partially determines the extent to which patients value patient-centered care. Accordingly, it would be useful to compare the importance attributed to patient-centered care for a number of medical treatments and a number of demographic subgroups, where preferences are assessed using the same methodology. A family of questionnaires that is known as the Consumer Quality index (CQ-index or CQI) provides this opportunity.

The CQ-index is a Dutch instrument for measuring patient experiences. It is based on two other types of surveys: the American CAHPS (Consumer Assessment of Healthcare Providers and Systems) [21,22] and the Dutch QUOTE (quality of care through the patients' eyes) [23–26]. The CQ-index is characterized by its disease-specific and provider-specific focus as well as the assessment of patient priorities, which both derive from the QUOTE. The layout, response scales and standardized sampling, data collection, analysis, and presentation adopted for the CQ-index were taken from CAHPS. The CQ-index has been declared to be the national standard for measuring patient experiences and performance indicators of quality of care are frequently based on the CQ-index [27,28].

The present paper aims to explore further the potential differences in the importance of patient-centered care between patient groups with various health problems. Furthermore, differences between demographic groups will be examined. To that extent, data from the CQ-index were used on the following patient groups: hip or knee surgery, congestive heart failure, spinal disk herniation, rheumatoid arthritis, and malignant and benign breast abnormalities.

Research questions

(1) To what extent do patients from different patient groups value patient-centered care compared to the other healthcare aspects included in patient experience surveys?
(2) Are there any differences between patient groups in the importance they attribute to patient-centered care?
(3) Are there any differences between demographic subgroups in the importance they attribute to patient-centered care?

As it cannot be ruled out that potential differences between patient groups and demographic groups will be driven by the possibility that some patients rate everything as more important than others do, this possibility will also be examined in the present study.

2. Methods

2.1. Participants

All data were collected in the Netherlands. Patients were identified through insurance companies and/or hospitals and approached by mail using a procedure known as the Dillman method [29], which includes up to four mail shots if necessary. The dataset for patients who underwent hip or knee surgery consisted of 214 patients (response = 78.6%), the dataset for patients suffering from rheumatoid arthritis consisted of 343 patients (response = 59.6%), the dataset for patients suffering from spinal disk herniation contained 145 patients (response = 37.1%), the dataset for patients suffering from malignant and benign breast abnormalities consisted of 515 patients (response = 50.4%), and the dataset for congestive heart failure consisted of 118 patients (response = 41.5%). The aforementioned patient groups were selected because they represent a wide variety of conditions and because the surveys for these patient groups contained comparable items concerning patient-centered care. Data on the demographic characteristics (age, self-rated health, education and gender) are presented in Table 1. The studies in which the data were collected were performed in accordance with the declaration of Helsinki.

2.2. Measurement of patient-centered care: construction of a composite measure

For CQ-index surveys, the preferences of various patient groups are identified through focus group discussions that aim to identify important elements of care from the patient perspective that will be included in the survey [30]. Subsequently, the relative importance of each element is assessed using a questionnaire. The survey consists of a list of items for which patients may rate the importance. An example of a survey item could read 'To what extent do you think it is important that you are able to ask questions?' accompanied by four response categories (i.e. not

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