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Assessing patient-centered communication in a family practice setting: How do we measure it, and whose opinion matters?

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ABSTRACT

Objective: This study evaluated variables thought to influence patient's perceptions of patient-centeredness. We also compared results from two coding schemes that purport to evaluate patient-centeredness, the Measure of Patient-Centered Communication (MPCC) and the 4 Habits Coding Scheme (4HCS).
Methods: 174 videotaped family practice office visits, and patient self-report measures were analyzed.
Results: Patient factors contributing to positive perceptions of patient-centeredness were successful negotiation of decision-making roles and lower post-visit uncertainty. MPCC coding found visits were on average 59% patient-centered (range 12–85%). 4HCS coding showed an average of 83 points (maximum possible 115). However, patients felt their visits were highly patient-centered (mean 3.7, range 1.9–4; maximum possible 4). There was a weak correlation between coding schemes, but no association between coding results and patient variables (number of pre-visit concerns, attainment of desired decision-making role, post-visit uncertainty, patients' perception of patient-centeredness).
Conclusions: Coder inter-rater reliability was lower than expected; convergent and divergent validity were not supported. The 4HCS and MPCC operationalize patient-centeredness differently, illustrating a lack of conceptual clarity.
Practice implications: The patient's perspective is important. Family practice providers can facilitate a more positive patient perception of patient-centeredness by addressing patient concerns to help reduce patient uncertainty, and by negotiating decision-making roles.

1. Introduction

1.1. Patient-centered care versus patient-centered communication

Patient-centeredness is a goal of most healthcare practitioners, but a difficult concept to define and measure. Generally we think of this concept as referring to individual patient–provider interactions, however the concept of patient-centeredness is also being used by hospitals and other organizations as a way of providing quality patient care [1]. Measuring patient-centeredness can be challenging, and depends on the conceptual operationalization of patient-centeredness. To measure and evaluate patient-centeredness for patient–provider interactions specific verbal coding schemes such as the Measure of Patient-Centered Communication (MPCC) [2] and the 4 Habits Coding Scheme (4HCS) [3] that purport to measure the concept of patient-centeredness have been developed.

Patient-centered care and patient-centered communication are two interwoven concepts relating to the composite term patient-centeredness that indicates a desire to address the individualized nature of each patient's values, needs, and concerns. Patient-centered care has been associated with a large variety of positive patient outcomes such as adherence to treatment, improved health, and satisfaction [4]. Moreover, patient-centered care has been defined as one of 6 indicators of quality care by the IOM [5]. The Picker Institute suggests that patient-centered care encompasses 8 dimensions: (1) respect for the patient's values, preferences, and expressed needs; (2) the provision of information and education; (3) access to care; (4) provision of emotional support; (5) respecting the involvement of family and friends; (6) providing for continuity and secure transition between health care settings; (7) ensuring physical comfort; and (8) ensuring coordination of care [6]. One popular definition that ties these ideas together is that patient-centered care provides the care that the patient needs in the manner the patient desires at the time the patient desires [7].

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Patient-centered communication, on the other hand, is considered a component of patient-centered care, encompassing four communication domains: the patient's perspective, the psychosocial context, shared understanding, and sharing power and responsibility [8]. Another more broad definition of patient-centered communication is "care that is respectful of and responsive to individual patient preferences, needs, and values" [4] and that demonstrates partnering skills and relationship building [9–11]. Yet another accepted definition of patient-centered communication is offered by Epstein and Street who suggest that patient-centered communication includes 6 components: fostering healing relationships, exchanging information, responding to emotions, making decisions, managing uncertainty, and enabling patient self-management which also includes facilitating patient navigation and patient empowerment [12].

As discussed by Epstein et al., there are considerable conceptual and measurement difficulties inherent in evaluating both patient-centered care and patient-centered communication, beginning with a lack of conceptual clarity of these terms [8]. Although it is mathematically possible to achieve inter-rater reliability among coders in terms of assigning values to communication behaviors, without clear conceptual definitions the construct validity of instruments purporting to measure patient-centeredness must be questioned.

1.2. Communication skills

Communication is one of the most important variables in the patient–provider relationship and has long been associated with the patient's perception of quality of care, including provider interpersonal and technical competence, as well as predicting patient satisfaction with the patient–provider relationship [13]. More recent research has linked provider communication skills with health outcomes [14]. Provider communication and interpersonal skills have been associated with health related and professional outcomes such as patient symptom management, nature and quality of information given to patients, decision making and treatment choice, uncertainty and distress, cost of care, and malpractice suits [15–24]. Finally, provider communication skills such as being receptive to verbal and nonverbal patient cues and concerns have been shown over time to be especially beneficial to understanding and addressing patients' emotional issues [25].

Methods for evaluating competency in communication and interpersonal skills are less well developed and include patient satisfaction surveys, audio or video recording of real or simulated patient encounters, and behavioral checklists [26]. However, while it is relatively easy to code the absence or presence of verbal and nonverbal communication behaviors (achieving satisfactory inter-rater reliability), it is difficult to know exactly which behavior elicited a specific patient response such as the patient's perception of provider communication [26]. Further, most communication coding methods are descriptive rather than evaluative in that specific communication and interpersonal skills are noted as present or absent, but not grouped in conceptual categories (e.g. behaviors that indicate provider empathy) along a continuum that allows for teaching, and evaluation of improvement, in provider communication competency. In addition, there is a lack of integration of theoretical principles and specificity of concepts (such as patient-centered communication) with evaluative techniques. Finally, there is the potential for evaluative subjectivity and bias when standardized communication evaluative criteria are not used [3].

1.3. Theoretical approach

The patient-centered clinical model developed by Stewart et al. [27] suggesting that patients discuss illness events within the context of his/her personal situation, was used to guide this research. In turn patients and providers strive to achieve mutually agreeable decision-making roles, a common understanding of the problem and consensus on goals for treatment.

Uncertainty in Illness theory also informed this study [28,29]. Patient-provider communication is a key construct in Uncertainty in Illness theory [17]. Providers are seen by patients as key figures that can provide information and answer patient questions which in turn can reduce patient uncertainty about an acute episodic illness event. In some situations such as life threatening illness (HIV) uncertainty reduction may not be the goal, instead maintaining uncertainty is sometimes seen as a way of preserving hope [30]. However, because this study involved family practice patients seeking care for acute events we consider reducing uncertainty desirable in this context.

In summary, the aims of this study were to: (1) further understanding about how patients subjectively perceive provider communication, (2) determine if the ability to successfully negotiate decision-making roles, the number of pre-visit patient concerns and level of post-visit uncertainty contribute to a patient's perception of patient-centered communication, and (3) compare results from two theoretically based coding schemes that include dimensions of patient-centered care and patient-centered communication, and purport to evaluate patient-centeredness: the Measure of Patient-Centered Communication (MPCC) [2] and the 4 Habits Coding Scheme (4HCS) [3].

2. Methods

2.1. Recruitment

After approval by the Institutional Review Board patient and provider participants were recruited from two university owned family practice clinics (Table 1). During the development of this study we met with clinic office managers and staff on a regular basis. Great care was taken to understand office procedures and to develop rapport with clinic personnel. Once recruitment began we regularly assessed our impact on the clinic by meeting with clinic managers and making every attempt to not disrupt clinic flow. This approach strongly contributed to our ability to successfully recruit both providers and patients.

Providers in both family practice clinics represented interns, medical residents, and fellows as well as full time physicians. Inclusion criteria required all patients to be age 18 years or older and primarily seeking care for a new problem (as opposed to a follow-up visit for a previously treated problem). When patients met inclusion criteria the office receptionist alerted them to our presence in the clinic lobby. If patients approached us, indicating a willingness to hear about the study, the study was explained and patient questions were answered. One hundred and eighty-eight adult patients and 21 medical providers were recruited. Only one provider declined participation. Because fourteen patients did not have video-recordings of their visit all analyses for this paper are based on 174 patients.

2.2. Instruments and procedures

Provider self-reported data included demographic and professional information (e.g. length of time in practice). Patient self-reported pre-visit data included demographic information (age, sex, length of time attending the clinic), their number of concerns, and desired decision-making role (the control preferences scale; CPS) [31]. Because patients often see a different provider each time they visit due to the teaching mission of these clinics and faculty turnover we were not able to determine the length of the patient–provider relationship, only the length of time patients had been