

The clinical context and patient participation in post-diagnostic consultations

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Abstract

Objective: Although patient participation is an important feature of patient-centered health care, few studies have examined how the clinical context affects patient involvement in medical encounters. This investigation examined the way patients communicate with physicians in two diverse post-diagnostic settings, post-angiogram consultations and initial lung cancer visits.

Methods: From transcripts and audiorecordings of post-angiogram consultations ($n = 88$) and initial lung cancer visits ($n = 62$) within a VA hospital in the United States, three measures of patient participation were coded—number of active participation behaviors (questions, acts of assertiveness, and expressions of concern), proportion of patients' utterances in the form of active participation, and conversational involvement (ratio of patient utterances to physician plus patient utterances). Mixed linear regression procedures assessed the independent effects of the clinical setting, physicians' facilitative communication (partnership-building and supportive talk), and patients' age, education, and ethnicity on patient participation.

Results: Not only was their less talk in the post-angiogram consultations compared with the lung cancer visits, heart patients also were less conversationally involved (accounted for 25% of the talk) than were lung cancer patients (45% of the talk) and their doctors used proportionally less facilitative talk than did the lung cancer physicians. In both settings, patients were more conversationally engaged when proportionally more of the physicians' talk was facilitative.

Conclusions: The clinical context has a profound effect on patient participation. However, within individual settings, physicians can increase patient involvement by using partnering and supportive communication.

Practice implications: Clinicians and administrators should assess clinical practices that restrict patient involvement in ways that could affect quality of decision-making.

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1. Introduction

Patient participation in medical consultations is an important component of patient-centered care and can contribute to improved outcomes [1,2]. Patients who express concerns, state preferences, and ask questions often are more satisfied with care, have a stronger commitment to therapeutic regimens, and even experience better health

following the consultation [3–8]. While studies have examined the effects of physician and patient factors on communication in medical encounters, only recently have researchers investigated how the clinical context impinges upon these interactions. This investigation analyzed patient participation, as well as the physician facilitation of patient involvement, in two distinct post-diagnostic scenarios, post-angiogram consultations and initial lung cancer visits.

Different clinical settings obviously vary along a number of dimensions including the medical specialty, the health condition, standards of care, time allotted for the visit, type

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of health care facility, and so forth [9,10]. At the VA Medical Center where this investigation took place, post-angiography patients were seen in the cardiac catheterization laboratory within an hour of the procedure and after they have come out of sedation. These visits are relatively brief, typically less than 10 min and many less than 5 min. The lung cancer visits, on the other hand, are ambulatory, conducted in an outpatient clinic setting, and are relatively long (up to 30 min). In spite of these differences, post-angiogram and lung cancer consultations do share one important characteristic—in both, physician and patient discuss diagnostic findings, consider treatment options, and make treatment decisions. Hence, patient participation, at least to the degree that the patient wishes or needs to be involved, is a critical part of each consultation.

We examined differences between the two settings regarding the degree to which patients asked questions, were assertive (i.e., sharing opinions, stating preferences, making requests), and expressed concerns and other negative feelings. These are considered ‘active’ forms of patient participation because of their influence on physician behavior and medical decisions [11]. For example, patients who are more inquisitive, assertive, and expressive generally receive more information, more reassurance and support, and more personalized treatment plans from physicians compared to more passive patients [12–14]. On average, active participation behaviors comprise 10–20% of the patient talk, significantly less than the total of other communication behaviors (e.g., giving information, social talk) [13–15].

While the sheer difference in the length of the post-angiogram and lung cancer visits will account for some differences in the *frequency* of active participation behaviors, we were primarily interested in differences in the *pattern* of communication as revealed in the proportion of the patients’ communication in the form of active participation and in the patient’s degree of conversational involvement (the ratio of the patient’s talk to the total talk in the consultation). By using proportional measures, we can control for variability in visit length between the two settings.

Given differences in visit length alone, we hypothesize that lung cancer visits will be characterized by proportionally more active patient participation than will the post-angiogram interactions. Relatively brief visits often limit information-exchange [16,17] and lead to more controlling behavior from the doctor (more biomedical questions and directives, less partnership-building) [18]. Longer consultations, on the other hand, generally allow for more patient participation as well as more physician attention to concerns raised by the patient [16,19–22].

However, other factors within the clinical setting also may affect patient participation. For example, patients often become more involved in the encounter and in decision-making when their physicians use partnership-building and other types of facilitative communication (e.g., empathy,

encouragement) [13,14,23–28]. By asking for the patient’s views, using open-ended questions, accommodating the patient’s preferences, and offering support, the doctor is legitimizing the patient’s perspective as well as creating expectations and opportunities for the patient to discuss needs and concerns [11]. Thus, regardless of the clinical setting, patient participation will likely be greater when proportionally more of the physicians’ communication is partnering and supportive.

Finally, individual differences in patients’ communicative styles may also account for variability in patient participation. For example, middle-aged, more educated, and white patients often are more expressive and assertive than are their counterparts [7,28–31]. Thus, a final research question focused on whether, after controlling for the clinical setting, there were differences in patient participation related to the patient’s age, education, and ethnicity (white versus African-American).

2. Methods

2.1. Research setting and participants

Patients and physicians were affiliated with a large Veterans Affairs (VA) Medical Center in the southern United States. The post-angiography consultations are relatively brief interactions (typically 5 min or less) in which the physician and patient discuss the findings and then decide on treatment that may include doing nothing, ordering more tests, performing coronary angioplasty and inserting a coronary stent, or bypass surgery. The initial lung cancer visits, on the other hand, are relatively long interactions (up to 30 min) where the physician and patient discuss the biopsy results and treatment options that may include supportive care, radiation, chemotherapy, and surgery. The research received IRB approval, and all patients and physicians provided informed consent.

2.1.1. Post-angiogram consultations

These data are from a previous study [32], the purpose of which was to describe patterns of physician–patient communication following invasive procedures. The post-angiogram consultations took place in the catheterization laboratory within an hour after the catheterization. Of 190 patients eligible for the study, 148 consented to participate. Due to audio-recording problems and incomplete consultations, 43 consultations were not usable, and 13 others were excluded because the patient did not complete the demographic survey, thus creating a sample with 92 interactions. While sedatives and analgesia are not routinely given in the cath lab, some patients ($n = 19$, 21%) received conscious sedation with midazolam (1 mg) prior to insertion of the catheter sheath, seven patients received an antihistamine to prevent or treat an allergic reaction to intravenous contrast dye, and three patients received

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