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Speech-language pathologists' preferences for patient-centeredness

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ABSTRACT

Purpose: Preferences for patient-centeredness is an important indicator in healthcare service delivery. However, it remains largely unexplored in the field of communication science and disorders. This study investigated speech-language pathologists' (SLPs) preferences for patient-centeredness

Method: The study involved a cross-sectional survey design. SLPs (n = 102) fully completed the modified Patient-Practitioner Orientation Scale (PPOS; Krupat et al, 2000) and also provided demographic details. Data were analyzed using descriptive statistics, correlation, and linear regression methods.

Results: Mean PPOS scores indicated that SLPs value patient-centeredness. There was a strong positive correlation among sharing and caring subscales with the full-scale. Results from the linear regression modeling suggested no relationship between demographic factors and preferences for patient-centeredness.

Conclusions: SLPs value patient-centeredness, although there may be regional and cultural variations. Qualitative investigations may help uncover dimensions of patient-centeredness that were not captured in the PPOS scale. In addition, further research should explore congruence in preferences for patient-centeredness among SLPs and patients.

1. Introduction

Over the past few decades, attention to patient-centered approaches in healthcare has been increasing. Today, these approaches are considered central to healthcare management and have been linked to improved healthcare quality and outcomes (Epstein & Street, 2011; Saha, Beach, & Cooper, 2008). Even though considered crucial to care, implementation and adoption of patient-centered care models are dependent on practitioner preferences for patient-centeredness (Krupat et al., 2000). While many practitioners have adopted patient-centered methods, there are varying labels, definitions, preferences, and evidence of patient-centered approaches across healthcare contexts (Liberati et al., 2015). For example, models of patient-centered approaches have been developed in both medical and allied health fields; however, allied health models are significantly different due to the greater inclusion of rehabilitation (Grenness, Hickson, & Laplante-Lévesque, 2014). In the allied health profession of audiology, recent research highlights trends in audiologists having high preferences for patient-centered approaches (Manchaiah et al., 2014). However, in speech-language pathology, another allied health profession, preferences for patient-centered approaches are unknown. DiLollo and Favreau (2010) emphasize the need for speech-language pathologists (SLPs) to incorporate patient-centered care into their

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clinical practice.

1.1. Patient-centeredness

The term patient-centeredness has been described as acknowledging every patient "as a unique human being" (Balint, 1969). Healthcare provision that respects and reacts to patient needs, values, and preferences to guide clinical decisions is said to follow a patient-centered approach (Greiner & Knebel, 2003; Poost-Faroosh, Jennings, & Cheesman, 2015). An important aspect of patient-centeredness in allied health is a clinical focus on the development of individualized rehabilitation programs (Cott, 2004). There is no current universal model for this development, but most achieve individualization and patient-centeredness following some key components of care (Kitson, Marshall, Bassett, & Zeitz, 2012; Mead & Bower, 2000). The first of these components is assuming a biopsychosocial perspective of the patient disorder, considering its impact on genetic composition, mental health and personality, and sociocultural environment (Engel, 1981). Another is to respect the "patient as a person," considering the individuality of patients rather than defining patients by their diagnoses (Bower, 1998). Shared knowledge, power, and responsibility between the clinician and patient is another component that promotes individualization and patient-centeredness. It is through this shared power that patients are encouraged to have greater involvement and accountability for their responsibility in their healthcare (Grol, de Maeseneer, Whitfield, & Mokkink, 1990). This type of shared vision leads to a therapeutic alliance between clinician and patient and yields agreement on goals and an understanding of the context of emotions in care (Mead & Bower, 2000). The final component is for clinicians to consider their impact upon the clinician and patient dynamic. The notion of considering the clinician as a person includes reviewing potential personal factors (e.g., interpersonal and emotional responses) of the clinician that may affect a patient-centered approach (Winefield, Murrell, Clifford, & Farmer, 1996).

In speech-language pathology, patients receiving speech therapy services seem to be aware of components of patient-centered approaches and believe that these mechanisms affect their therapeutic outcomes. Fourie (2009) found that while patients of SLPs value linguistic or physical improvements, positive personal relationships with SLPs and specific therapist qualities (e.g., being gracious and inspiring) were more frequently linked with reductions in alienation, confusion, and demoralization. Also, Brown, Worrall, Davidson, and Howe (2012) compared the perceptions of individuals with aphasia (IWA), their family members, and SLPs. In this study, IWA and family members described therapeutic needs and values that were in contrast to SLP perceptions of having success in living with aphasia. For instance, IWA and family members desired therapy tasks and goals that were centered on strengths. They perceived that some tasks selected by SLPs promoted discouragement and hopelessness.

In recent years, the use of patient-centered approaches has become more common in speech-language pathology. Theoretical frameworks in aphasia have emphasized components of patient-centeredness, and these factors are now conceptualized as overarching principles that guide service delivery (e.g., Kagan, Black, Duchan, Simmons-Mackie, & Square, 2001; LPAA Project Group, 2001). Counseling techniques and the entrance of positive psychology into speech-language pathology have promoted opportunities for developing therapeutic alliances between clinicians and patients (Holland & Nelson, 2013). Also, there has been a greater focus on patients as experts in their own conditions (Byng & Duchan, 2005; Pound, Duchan, Penman, Hewitt, & Parr, 2007). In dysphagia, shared decision-making has been suggested as a means to overcome patients with swallowing problems rejecting modifications to their diet via the development of algorithms and decision tree models (Kaizer, Spiridigliozzi, & Hunt, 2012).

Despite these advances, interventions that employ patient-centeredness appear to be the exception rather than the rule. While patient-centered approaches are a key principle of care, Ratner (2006) suggests that professionals in communication disorders clinically understand the disorders but are further behind in understanding their patients. In fact, some techniques used by SLPs within therapeutic interactions, such as exposed corrections in impairment-focused aphasia therapy, have been shown to reinforce a power asymmetry between clinicians and patients, highlight incompetence, and contribute to negative self-evaluations (Shadden & Agan, 2004; Simmons-Mackie & Damico, 2008). SLPs' awareness of these practices and the extent to which therapeutic practices impact patient-centeredness remain largely unknown.

1.2. *Audiologists' preferences for patient-centeredness*

Research evidence regarding preferences for patient-centeredness among audiologists provides direction for examination of preferences among SLPs. Laplante-Lévesque, Hickson, and Grenness (2014) utilized a modified version of the Patient-Practitioner Orientation Scale (PPOS; Krupat, Putnam, & Yeager, 1996) to examine audiologist preferences for patient-centeredness. The authors reported that audiologists in Australia have high preferences for patient-centeredness. Higher preferences were noted among audiologists with increasing age and greater years of practice. Also, some differences among preferences were found based on employment characteristics. For example, audiologists who teach, educate the community, and work in industrial audiology had higher preferences than audiologists in other workplace settings. Additionally, weaker preferences for patient-centeredness were noted for audiologists in private practice and adult diagnostics than other audiology work environments.

Manchaiah et al. (2014) extended this research in India, Portugal, and Iran. Results indicated that audiologists had preferences for patient-centeredness, but it varied across clinical situations (e.g., if the audiologist should choose and lead discussion topics in an appointment; if a patient should receive full explanation of their condition). Further, there were significant differences between preferences across the countries with Portugal having greater preferences for patient-centeredness than India or Iran. In comparison to Laplante-Lévesque et al. (2014), similar patterns of variation across clinical situations were found. Australian and Portuguese audiologists had similar patient preferences. Manchaiah et al. suggested that this may be due to variation in training programs and cultural differences.