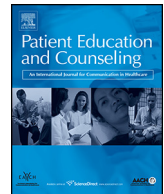




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Patient perception, preference and participation

Patients' preferences for patient-centered communication: A survey from an outpatient department in rural Sierra Leone

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ABSTRACT

Objectives: To investigate patients' preferences for patient-centered communication (PCC) in the encounter with healthcare professionals in an outpatient department in rural Sierra Leone.

Methods: A survey was conducted using an adapted version of the Patient-Practitioner Orientation Scale (PPOS) as a structured interview guide. The study population was drawn from the population of all adults attending for treatment or treatment for their children.

Results: 144 patients were included in the analysis. Factors, such as doctor's friendly approach, the interpersonal relationship and information-sharing were all scored high (patient-centered) on the PPOS. Factors associated with shared-decision making had a lower (doctor-centered) score. A high educational level was associated with a more patient-centered scoring, an association that was most pronounced in the female population.

Conclusion: The results provide an insight into the patients' preferences for PCC. Patients expressed a patient-centered attitude toward certain areas of PCC, while other areas were less expressed. More research is needed in order to fully qualify the applicability of PCC in resource-poor settings.

Practice implications: Stakeholders and healthcare professionals should aim to strengthen healthcare practice by focusing on PCC in the medical encounter while taking into considerations the patients' awareness and preferences for PCC.

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1. Introduction

Patient-centered communication (PCC) is a communicative approach used in the medical encounter between patients and healthcare providers with the purpose of achieving high quality care [1,2]. Epstein et al. has defined one model of PCC encompassing 4 key areas; (1) eliciting and understanding the patient's perspective, (2) understanding the patient within his/her unique social context, (3) reaching a shared understanding of the problem and its treatment and (4) helping patients to share power and responsibility through involvement in making choices [3]. Above all, PCC stresses the importance of addressing a patient perspective in the consultation process, as this is known to improve factors like patient satisfaction, adherence to treatment and self-management, especially in relation to chronic diseases [3–6]. In that vein PCC has become an important approach in building modern high-quality healthcare institutions and practices [2,4,7–10].

Despite increased focus on primary healthcare in developing countries [11,12] little attention has been given to the relevance, importance and applicability of PCC in these settings. However, research has addressed patient-centered issues closely linked to PCC: by assessing consultations among non-western people in South Africa one study found that patient-centered consultations were associated with patients feeling understood, patient-practitioner agreement, symptom resolution and concern resolution [13]. A study from Bangladesh has documented the importance of meeting patients' expectations and communicating openly with the patients, who will otherwise seek for other healthcare options [14]. Findings from Sierra Leone have revealed that if patients experience disrespect or neglect from healthcare personnel at public health facilities they are more inclined to seek help in traditional medicine [15]. Patients in an Indonesian study ranked factors like receiving full information, receiving intelligible answers and being encouraged to ask questions as important and related to satisfactory with received treatment [16]. A study from Guinea investigated patients' perceptions of primary healthcare quality among the rural population. Elements such as good interpersonal relationships with the healthcare professional and the feeling of being well-treated was rated high among the study

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population [17]. Other studies from Sub-Saharan Africa point to the importance of refining communication between patients and healthcare providers when improving for instance adherence to medicines [18–20].

Although PCC seems relevant in relation to healthcare systems in low-income settings, to our knowledge only two studies have focused explicitly on PCC. These studies, conducted in Nepal and Brazil, respectively, have addressed patients' preferences for PCC and showed a need for increased attention to the communication practice and thus suggested that the concept of PCC increasingly becomes integrated into medical training [21,22]. There appears to be no studies assessing patients' preferences toward the full concept of PCC in Africa. Western studies on PCC suggest a correlation between more patient-centered beliefs and being female, younger, more educated and having a higher income [10,23]. However, these findings cannot be assumed to be the same in African societies. In order to raise the attention to PCC in low-income countries this study focuses on Sierra Leone and has two main objectives: (1) To investigate and describe patients' overall preferences for PCC; (2) To investigate and describe the influence of the demographic variables of sex, age and education in relation to patients' preferences for PCC.

Sierra Leone is among the world's poorest countries and still struggling to recover from 10 years of civil war ending in 2001. The National Health Sector Service Plan [24] sets out priorities and plans of action in improving the general poor health condition of the population manifested in alarming health indicators. In 2011 the country spent less than 1.5% of GNP on public health [25]. Life expectancy at birth is 47 years, maternal mortality rate reaches 970 pr. 100,000 live births [26], and in 2011 the under-5 mortality was found to be 192 out of 1000 live births [25]. In order to reduce the maternity- and under-5-mortality, the government of Sierra Leone launched the Free Health Care Initiative (FHCI) in April 2010. The FHCI is offering medicines and healthcare free of charge to pregnant and breast-feeding woman and children under the age of five. FHCI has resulted in a massive increase in the demand of healthcare in public institutions (mainly hospitals and health centers), which has not been met with allocation of additional resources [27,28]. In general terms the public healthcare sector lacks funding, resources and human capacity to provide basic medical care to the majority of the Sierra Leonean population [29,30]. At the same time the existing pluralistic health care system found in Sierra Leone makes people consult many different providers including friends and relatives, drug peddlers and traditional healers before reaching the professional health sector [15,31]. Most medicines are easily available within the informal sector and traditional herbalists and healers are in general considered as trustworthy sources of care [32,33]. Hence, the context needs to be taken into consideration when aiming to strengthening the quality of primary healthcare in the professional sector [34,35].

2. Methods

The research presents data from a cross-sectional survey among patients attending an Out-Patient Department (OPD) using an adapted version of the Patient-Practitioner-Oriented Scale (PPOS). Krupat et al. has operationalized the concept of PCC into the PPOS, thereby offering a practical and simple tool for measuring preferences for PCC [36]. PPOS encompasses the model of Epstein and constitute the theoretical and methodological approach of the present research. The PPOS has been validated in a number of studies [9,22,23,37–41].

The research was carried out from October 2011 to June 2012 in the OPD of a 100-bed teaching hospital in a rural northern area of Sierra Leone. The original PPOS is an 18-item self-administration

questionnaire used for measuring healthcare professionals' and patients' respectable orientations toward control in their relationship by ascertaining their preferences for either a patient-centered or doctor-centered communication approach [36]. The PPOS used in the present research has been adjusted and contains 19 statements that (as in the original PPOS [36]) form 2 subscales: The *sharing subscale* and the *caring subscale*, which align the PPOS with the theoretical approach used by Epstein et al. [3]. The caring subscale investigates attitudes toward the first 2 areas: Patient Perspective and Patient Psychosocial Context. Likewise, the sharing subscale corresponds to the last 2 areas: Sharing Understanding and Sharing Power and Responsibility.

2.1. Testing and modification of the PPOS

In order to evaluate the validity and usability of the PPOS questionnaire in practical terms the original PPOS was initially piloted among five hospital employees. Originally the PPOS is to be answered on a 6-point Likert Scale, where 1, strongly agree and 6, strongly disagree. The piloting revealed difficulties in responding on a not-defined scale like the Likert Scale. Hence, the scale was changed to defined answers (cf. Appendix A). Furthermore, the piloting showed troubles in responding to statements formulated in third-person terms. As the literacy level among the hospital employees was assumed higher than among the study population, it was found appropriate to simplify the wording of the statements to first-person. The same adjustment was made and validated in a similar study from rural Nepal [42]. Additionally, the pilot study formed the basis for modifications of the wording of statement no. 6, 10, 11, 15, 17 and 18 from the original PPOS questionnaire yet assuring the same overall interpretation of the statements. For instance, statement 6 originally sounds: "When doctors ask a lot of questions about a patient's background, they are prying too much into personal matters". The word *prying* was not understood and the statement was therefore changed to: "The doctor should not ask me a lot of personal questions in order to treat me". Also the pilot study revealed that culture and background are understood as two very different conceptions. People interpreted background as relatives, household, education level etc. In a similar way they interpreted culture as religion, beliefs and secret societies. The combination of the two statements in one statement (as in the original PPOS) revealed inconsistent answers and blurred the understanding of the statement, thus the statements were divided into two separate statements (numbered 16 and 17). The adjustments were tested among 10 patients from the target population while also training the locally hired research assistant in executing the interviews.

Apart from 3 items (9, 13, 18) the statements are all expressed toward a doctor-centered orientation. The 3 statements worded in patient-centered terms are reverse-scored. Therefore, for all items, scores of 1 represent the most doctor-centered orientation and scores of 6 the most patient-centered orientation. The original PPOS and the adapted statements are found in Appendix A.

2.2. Practical conductance of the study

At the OPD the patients present directly from the street and the study sample was drawn from the population of all adults presenting for treatment of themselves or their children. On average 50 patients visit the OPD every day (Monday-Friday) and patients spend most of the day waiting for consultation, test results and dispensing of medicine. The research assistant began the day by presenting the study to those present in the waiting room. Interested respondents were registered. Informed consent of respondents was obtained orally after information was read out for each followed by clarification if necessary and agreement.

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