Patient-centredness – what does it mean?

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Abstract

Objective: In order to provide a clearer framework for future conceptual and empirical development of the concept of patient-centredness, this study provides a thematic synthesis of the literature about the concept from the past 15 years. This is done with the aim of uncovering the meaning and the definition of patient-centredness today.

Method & design: We conducted a systematic literature search in PubMed. A publication date limit was set from January 2000 until October 2015. The search string focused on articles categorized under the MeshTerm 'patient centered care' and/or contained the word 'patient-centredness' including its linguistic variations. We included original articles which contained a definition of the concept. All included articles were analyzed thematically and matched, if possible, with the definitions of patient-centredness described by Mead & Bower in 2000, using their descriptions as a starting point.

Results: Ninety articles were included. Five dimensions stood out as the five most mentioned: 'biopsychosocial', 'patient as person', 'sharing power and responsibility', 'therapeutic alliance' and 'coordinated care'.

Conclusion: The weight and dynamics of the dimensions of patient-centredness are unevenly distributed favouring the two dimensions ('sharing power and responsibility' and 'therapeutic alliance'), which are concerned with the interaction between doctor and patient. Four of the five dimensions presented by Mead & Bower were readily traceable in the included articles. Furthermore, 'coordinated care' was identified as a new dimension.

Practical implication: The conclusion of this study suggests, that in order for the healthcare system to act patient-centred anno 2015, empowerment of the patient as well as tending to the psychological and social sides of illness is recommended.

Introduction

During the past 45 years the concept of 'patient-centredness' has grown from a theoretical approach into a paradigm, and a core dimension of what is considered to be high quality health care.(1) Praised by IOM (Institute of Medicine)(1), patient-centredness is becoming a deeply integrated part of the way physicians are expected to practice and treat patients worldwide. It is even taught during the medical education.(2) And to promote this development thousands of academic articles describe and reflect upon this concept. (3)(4)(5)

Despite this, there is still a lack of a universally agreed definition of the concept.(4) Patient-centredness can easily be confused with personalised medicine, which means using the patient's unique genetic map or individual biomedical parameters to optimize treatment. However, personalised medicine is a biomedical centred approach based on technology.

Lack of a universally agreed definition of patient-centredness hampers its usefulness and conceptual and empirical development. Enid Balint(6) and Stewart et al.(7) were among those who greatly influenced the initial conceptualization and meaning of patient-centredness from the late sixties. Enid Balint described patient-centredness as a way of understanding the patient as a unique human being. In order to understand the patient, the physician must try to enter the patient's world, to see the illness through the patient's eyes.(8) The subsequent definitions described the concept as containing different dimensions.

Among these descriptions are Stewart and co-workers' six dimensions of patient-centredness from 2001: Exploring both the disease and the illness experience, understanding the whole person, finding common ground, incorporating prevention and health promotion, enhancing the patient-doctor relationship, and being realistic.(7)

IOM likewise endorse the concept, using Gerteis´ six dimensions:

1. Respectful to patients' values, preferences, and expressed needs. 2. Coordinated and integrated. 3. Provide information, communication, and education. 4. Ensure physical comfort. 5. Provide emotional support, relieving fear and anxiety. 6. Involve family and friends.(1)

In 2000 Mead and Bower published a review of the previous literature containing the concept and they showed that the concept was not uni-dimensional but contained five dimensions:

1. Biopsychosocial perspective. 2. Patient-as-person. 3. Sharing power and responsibility. 4. Therapeutic alliance. 5. Doctor-as-person.(9)

We used Mead and Bower's five dimensions as a basis for analysis of patient-centredness. The aim of this study was to uncover the present meaning of patient-centredness and to explore the development of the meaning of the concept during the past 15 years. We performed a systematic review of the literature on patient-centredness published since Mead and Bower's review.(9)

Method

A systematic literature search was conducted in PubMed. The search was limited to a time period from January 2000 until October 2015. We produced a comprehensive search string in cooperation with a specialized librarian. The search string contained the word 'patient-centredness' and it's linguistic variations. We added the Mesh term 'patient-centered care' to the search string via "AND/OR". Finally, the citations had to contain one of the following words: 'concept', 'concepts', 'definition', 'dimensions', 'dimension', 'definitions' or 'multidimensional'. Only English citations were included.

Study selection

Two reviewers (EM & AD) independently screened titles and abstracts of all search hits and then collectively decided on which articles to include for further reading. Subsequently, all authors independently assessed these articles, and decided on which articles to include for further thematic analysis. There was great agreement among the authors and any cases of doubt were discussed until concensus. Two authors (EM & AD) read the remaining articles as full text versions to make sure that they contained a sufficient definition of the concept of patient-centredness to meet the inclusion criteria. Discrepancy was settled through debate with a third author (LD).

Inclusion and exclusion criteria

Inclusion criteria required access to the complete article. Articles should include a complete definition of patient-centredness, relevant for medical practice. Only peer reviewed, original articles were included, thus excluding commentaries and summaries.

Data extraction

For all included studies we extracted the definition and dimensions of patient-centredness.
In addition we extracted the following information:

- Publication year
- If the authors referred to a known definition patient centeredness
- The context of the article

Synthesis of results

The dimensions from each definition were categorized in a spreadsheet and paired with one or more of Mead and Bower's five dimensions. Each dimension found in the articles, was analysed thematically and discussed among the authors of this study (EM, LD & AD), before categorization. This was to ensure agreement. Themes that did not readily match one of Mead and Bower's dimensions were categorized as new dimensions.

Results

As shown in the flow chart (Figure 1) the search yielded 1563 citations. No duplicates were found. After the initial screening 140 articles remained. Many articles were excluded because they merely used the word patient-centred, without elaborating on it. Nine articles were inaccessible as full text. Forty-one articles were excluded. 18 articles due to not dealing with the topic, 20 articles defined patient-centredness insufficiently. Three articles were not original articles. Finally, 90 articles were included in our study.

Dimensions of patient-centredness

The analysis showed that while most of Mead & Bowers dimensions from 2000 were still relevant, the weight and dynamics of the dimensions were unevenly distributed. Particularly the dimension 'doctor as person' was mentioned considerably less in our included articles than the other four dimensions of patient-centredness. 'Sharing power and responsibility' and 'therapeutic alliance', the two dimensions relating to the relationship between doctor and patient and the notion of 'shared decision making', were the two most mentioned dimensions in the included articles when defining patient-centredness. In addition, a new dimension 'coordination of care' emerged as an independent dimension, with frequent mentions in the articles.

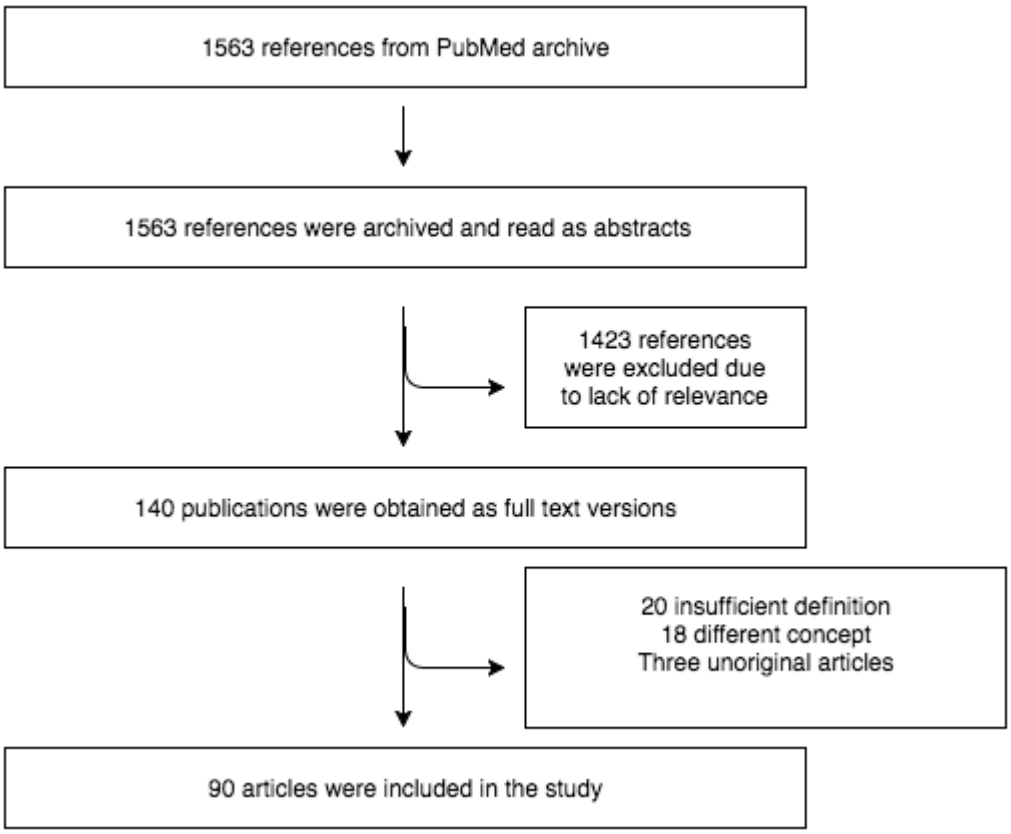

Figure 1 search process

Overview of the included articles

Most articles were published from 2010 and onwards. Patient-centredness was incorporated into these articles in many ways. A few authors describe an analysis of the concept to improve the understanding,(10)(11) some embed it in specific medical specialities (primary care, cancer, infertility, etc.),(12)(13)(3) while others construct methods for measurement.(14)(15)(16)

The authors most often referred to definitions of other authors or institutions. Mead & Bower's definition, the definition of the IOM (USA) and the Picker Institute (Scotland) were among the most frequently cited. Thus, most definitions found in the included articles covered few accepted definitions. Seventeen different definitions were registered in the articles. Moreover, the description of patient-centredness sometimes varied from author to author even if they referred to the same well-established definition.(17)(18)(19)(11) More than one third of all articles, mentioned that they considered the term patient-centredness to be vaguely defined. Appendix B shows a complete list of the included articles.

Thematic analysis

The following overview is the result of the thematic analysis of the complete data set. The five dimensions described below were the five most frequently mentioned dimensions in 70 included patient-centredness articles. Mead & Bower´s fifth dimension of patient-centredness ('doctor as person') was rarely mentioned and is therefore not included in the description. Instead 'coordinated care' showed to be a significant and new dimension and is therefore included. Figure 2 gives an overview of how many times the dimensions are referenced in the articles. The dimensions are listed in order of appearance and with a description of how they are described in the articles in addition to a brief definition.

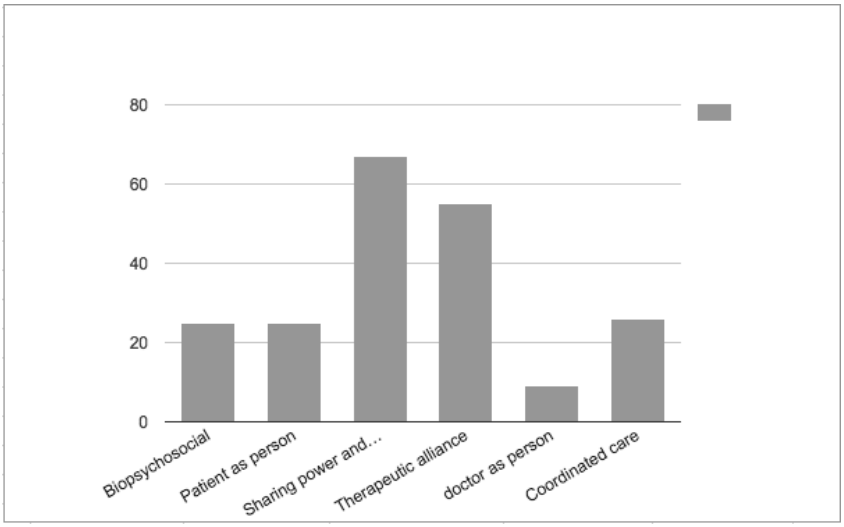

Figure 2 overview of the included dimensions and the frequency of mentions.

Sharing power and responsibility
This dimension appears in 66 articles.
The dimension was one of the two most frequently mentioned dimensions in the articles. Patient-centredness is described as calling for patient participation.(20) In the included articles it is described as: reaching 'common ground'(4)(11)(21)(8)(3)(15)(22)(23), ensuring 'empowerment',(24)(25)(26)(22)(27)(28)(29)(30)(31) and 'shared decision making'(32)(4)(33)(34)(35)(13)(36)(11)(37) among others.

"Rather than envisioning the patient as a passive ''recipient'' of care, a physician should empower patients to ask questions, receive and understand information, and participate in his or her own health care decisions. "(38) page 273.

This dimension is referred to as a the power shift between patient and physician(9) and the need for encouraging an egalitarian partnerships between patient and physician.(30) Overall 'sharing power and responsibility' is considered as having respect for patient autonomy,(39) where the patient is sufficiently informed by the physician in order to take part in the decision making.(20)

Therapeutic alliance
This dimension appears in 54 articles.
In our data extract this was one of the two most mentioned dimensions. Obtaining therapeutic alliance was, among others, described as 'building relationship'(40)(41)(42)(38), 'building an alliance'(13)(21)(37)(8)(24)(3)(15)(42) and as prioritizing communication between patient and physician.(34)(35)(11)(12)(37)(8)(26)(27)(39)
Mead and Bower describe:
"The development of a therapeutic alliance is a fundamental requirement rather than a useful addition. The therapeutic alliance is required for achieving the other dimensions".(9)

Coordinated care
This is a new dimension that was not a part of Mead & Bowers five dimensions of patient-centredness. However, it appears in 26 articles.
We have included it in our list, because it is seen as a core dimension in a great number of the articles. In the included articles it is described as: 'accessibility',(43)(17)(16)(10)(44)(18)(19)(24)(37) 'coordination'(34)(45)(46)(40)(47)(11)(12)(19) and 'continuity'(43)(17)(10)(18)(22)(24)(37) among others. It addresses the need for coordination and integration of the different segments of a patient's care-plan. This is

expected to result in a more continuous, healing and hassle free experience of the care pathway for the patient. Promotion of this dimension is described as in turn also reducing unnecessary usage of health care resources, thereby making health care more accessible and cost effective.(26)

Biopsychosocial

This dimension from Mead & Bower appears in 25 of the included articles.
This dimension is described as the practicing of a holistic,(39)(13)(37)(3)(48)(49)(16)(39) whole person(4)(35)(13)(11)(21)(50)(3)(15) or biopsychosocial approach(33)(13)(11)(21)(3)(15)(42)(51)(9)(38). The holistic approach has been considered a part of patient-centredness in general practice since the origin in 1969(6), and according to our data extract it appears to continue as such.

Engel described the dimension as affecting illness on three mutually interacting hierarchal levels: biologically, psychologically and socially. In order to treat the patient, it could be necessary to explore all three levels in the consultation.(9)

Patient as person

This dimension appears in 25 of the included articles.
The uniqueness of each patient is described as 'patient as person', (13)(52)(21)(8)(3)(15), and the need for obtaining the 'patient perspective',(4)(3)(53)(27)(16)(20) among others. It is a common feature of the description that every patient experiences illness differently, depending on how it may influence his or her current life. Mead & Bower explain this as:

'A compound leg fracture will not be experienced in the same way by two different patients; it may cause far less distress to the office worker than the professional athlete'.(9) page 1089

Inclusion of the patient's perspective is regarded as important information when treating the patient.(3) Patients are seen as experts on their own life. The data extract also pointed out that in order to treat a patient as a person, it is important as a physician to explore both the appearance of the disease and the patient's experience of illness.(22)

Other results

In addition, the search result contained articles, which mostly focused on the concepts of patient/family-centredness and person-centredness where the search word patient-centredness nevertheless appeared. We included 20 articles where this was the case. These articles were thematically analysed in the same way as the rest of the included articles, but kept separate from the main data extract. We found that the definitions of these concepts and the dimensions used to describe them, overlapped with the dimensions used to describe patient centeredness by Mead & Bower. The similarity of the different concepts is described in the work of Hughes and co-workers.(39)
The distribution of the five dimensions in person- and family centred articles, compared with the distribution of patient-centredness dimensions is comparable (see appendix A).

Discussion and conclusion

Statements of principal findings:

To elucidate whether Mead & Bower's five dimensions were still valid, we conducted this systematic review and synthesized the extracted data into an updated framework for future empirical and theoretical research. Despite the many different dimensions extracted from the included articles, most fitted well in groups corresponding to four of

the dimensions of patient-centredness described by Mead & Bower. This could indicate that four of the five dimensions of patient-centredness are still valid today. Mead & Bower's fifth dimension 'doctor as person' was mentioned less frequently and was consequently not described in the results. Finally, 'coordinated care' emerged as a new dimension based on the number of times mentioned in our extracted data.

Strength and weaknesses:

This paper is, to our knowledge, the first aiming to report on the development of the meaning and definition of patient-centredness since Mead & Bower´s review in 2000.

The present review has several methodological strengths: first, a research team with three researchers conducted it. Two authors screened all the references. All three authors participated in the inclusion process, and the study selection and the analysis were performed by at least two persons in order to strengthen reliability. We executed a relatively comprehensive search with the assistance of an experienced research librarian.

However, some limitations still apply: for reasons of resources we only searched PubMed, similarly to Mead & Bower,(9) and since we wanted only to include peer-reviewed studies, we did not search the grey literature. In addition, we did not snowball-search the selected studies for further material, due to resource reasons. Hence some relevant studies may have been missed.

We focused on the keyword 'patient-centred' and it's linguistic variations. In this way, we effectively excluded most articles describing concepts such as person-, client- and family-centredness. However, it is shown that these concepts bear great resemblance(39) so much that on a thematic level they are difficult to separate. Including these similar concepts would have produced a significantly bigger search result. This, however, would have been irrelevant to the study since we sought exclusively to explore the development of the meaning and definition of patient-centredness. Nevertheless, future research similar to Hughes et al.(39) might discover just how similar these concepts are. However, even though we limited our search to patient-centredness, articles dealing with the adjacent concepts emerged in our search as a separate analytical theme.

Other databases than PubMed might be included in future research in order to unveil a more nuanced rendering of patient-centredness.

Interpretation of the findings

The results of this study point out that the doctor-patient relationship should be seen as important and prioritized, as the two dimensions ('sharing power and responsibility' and 'therapeutic alliance') which represent this aspect are the most frequently mentioned. 'Biopsychosocial' and 'patient as person' represent one side of the relationship: the patient.

'Sharing power and responsibility' and 'therapeutic alliance' represent the interaction between the doctor and his or her patient. The other half of the relationship, 'doctor as person', the fifth dimension of patient-centredness described by Mead & Bower was mentioned considerably less frequently, even though every physician is as 'unique' as the patient he or she is treating. In general, the definition of patient-centredness within the recent 15 years, does, however, not include this aspect. The dynamics of patient-centredness are thus primarily weighted towards the relationship and the patient's individuality. Given that the dimensions 'sharing power and responsibility' and 'therapeutic alliance' are mentioned much more frequently than the remaining dimensions might be a result of a tendency towards a more individually tailored patient care.

'Sharing power and responsibility' and 'therapeutic alliance', the two dimensions concerned with the relationship between doctor and patient, contained the largest and most varied nomenclature addressing different aspects related to the basic understanding of these dimensions. Examples from the articles are 'common ground', 'trust', 'collaborate decision', 'shared decision making', 'support' and 'partnership' among others. This varying description may imply that it can be difficult to cover the whole of a healing relationship in one word.

Among our extracted data, a dimension not included by Mead & Bower, emerged. The dimension 'coordinated care' was mentioned just as frequently as 'biopsycosocial perspective' and 'patient as person'. This seemingly important dimension could well be a response to an ever more fragmented health care system. An increased focus on coordinating the care may be the realisation of a need to be able to diminish the risk of the patient falling through the safety net when different sectors and departments are involved in the care-plan.(54) Coordinating may also be seen as necessary in order to establish continuity of care for the patient.(55)

Implications for clinicians and politicians

When discussions about optimal care are performed and initiatives are described using concepts as patient-centredness, whether this is on a political-, scientific- or organizational level, it is important that all parties are talking about the same thing. During this thematic analysis, we identified 17 different definitions of patient-centredness, each describing the same basic concept in slightly different ways. Five dimensions were uncovered which make up the most general and agreed definition (of patient-centredness): 'biopsycosocial perspective', 'patient as person', 'sharing power and responsibility', 'therapeutic alliance' and 'coordination of care'. 'Coordination of care' had emerged as a new dimension, indicating the challenge of an increasingly fragmented health care. It may be meaningful that concepts such as person-centred and family-centred are used, but basically they describe the same attitude and approach as patient-centredness. This means that it is more important to reach agreement about the appropriate approach to the patients in the consultation, than the choice of words. In addition, the fragmentation of the health care system calls for a new awareness of coordinated or integrated care of patients.

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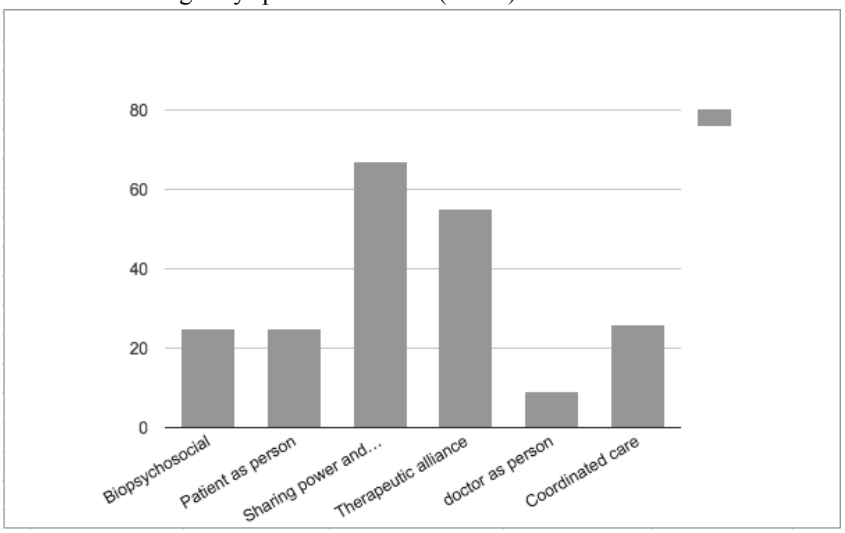
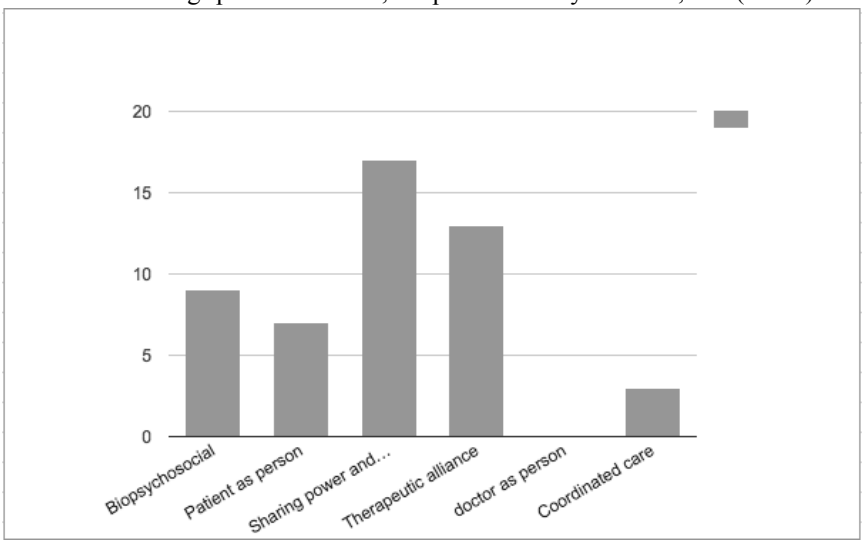
Appendix

Appendix A:

Articles containing only ‘patient-centred’ (N=70)



Articles containing ‘person centred’, or ‘patient-family centred’, etc. (N=20)



Appendix B:

Patient-centredness articles included in the study:

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Person-centredness or patient-family centredness etc. articles included in the study (separate from the patient-centredness articles):

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