Patient involvement in surgical care-Healthcare personnel views and behaviour regarding patient involvement

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Patient involvement in surgical care- Health care personnel views and behaviour regarding patient involvement

ABSTRACT

Background: All professions in surgical care have a responsibility to include patients in their health care. By Swedish law, all care should be done in dialogue with the patient. The essential part of health care is the meeting between patient and health care professional. In the interaction, a decision can be made, and needs can be identified to a safer care. Previous studies on patient participation have focussed on patients' perspectives in surgical care, but there is a paucity of studies about the personnel's perspective of estimated patient involvement in surgical care.

Aim: The aim of this study was to identify and describe health care personnel's view and behaviour regarding patient involvement in surgical care.

Method: A quantitative study with various professions was conducted. A validated questionnaire was used, remaining questions grouped under following areas: patient involvement, acute phase, hospital time, discharge phase and questions on employment and workplace.

Results: A total of 140 questionnaires were sent out to a surgical clinic in Sweden, and 102 questionnaires were answered. All professionals stated that clear information is an important part of patient involvement in surgical care. Statistically significant differences existed between the professions in the subscale information. Physicians rated their information higher than the registered nurses ($p = 0.005$) and the practical nurses did ($p = 0.001$). Hindrances to involving patients were lack of time and other priority tasks.

Conclusions: Professionals in surgical care graded information to be the most important thing for patient involvement. Participation in important decisions, including the possibility to express personal views and ask questions, are important factors for patient involvement. Barriers against patient involvement are lack of time and prioritization of other work activities.

KEYWORDS: information, surgical care, patient involvement, personnel's perspective, teamwork

INTRODUCTION

All professions in surgical care have a responsibility to involve their patients in their care. By Swedish law, all care should be done in consultation with the patient, and the patient's own opinions and questions should be taken into consideration. Human rights mean the right to be respected as a human being, and human rights also apply in health care (1). The core of health care is the meeting between the patient and the health care professional. In the interaction between patient and health care professional, decisions can be made, and needs can be identified. Patient involvement/participation is characterized as a relationship between patient and health care professionals. Over time, patients have become more active in their own care. Mutual interaction between patient and health care professionals is essential and an important component in achieving patient participation. The patient needs to be able to participate in the decisions made and have an active part in the treatment of symptoms and specific care (2-5).

Respecting and strengthening the patient are important characteristics of the health care professional (6). Patient participation can be related to aspects of care and decision-making, including self-care, education, and goal setting (7). Health care professionals should have a

person-centred perspective, but they sometimes need support in performing person centeredness systematically and consistently. Documenting decisions is important to maintain continuity and partnership (8). Good care is achieved when health care professionals and patients agree on how care should be carried out. The partnership is also a central part of person-centred care and is based on trust between health professionals and patients.⁹ By working in a person-centred way, care is improved. Person-centred care is the future, which is why decision-makers and management in health care must be willing to create models and support its implementation in health care (10, 11). Patient safety is not only affected by patient factors, such as age, sex/gender and occupation, but is also affected by encouragement and by obtaining information from caring staff (12, 13). There are obstacles to patients being active in their own care, which may include uncertainty in calling into question health professionals, difficulty having their requests for care honoured and being listened to. It can be challenging for health care professionals to respond to each individual patient. Patients who are more involved in their own care have increased feeling of safety (14). The challenge of creating good patient participation depends on the behaviour of health professionals. This means that non-supportive behaviour may be due to busy or stressed-out health care professionals (15). Both staff and patients prefer a pleasant atmosphere and a mutual relationship based on trust, which has a positive effect on teamwork (16). Oxelmark et al. believe that through cooperation with the patient, nurses can try to respect how the patient looks at their situation (17). There are obstacles when the patient takes a passive role and there is a lack of teamwork between professions. Teamwork is hampered by the care staff talking in a language the patient does not understand (medical terms) or talking over the patient's head (17). Professionals who collaborate effectively with other members of other professions stimulate and facilitate teamwork (18).

Surgical care is becoming increasingly advanced while care times are becoming shortened, and many surgical patients have advanced age and multiple morbidities. The working environment in surgical care can often be stressful, and there is currently a shortage of both health professionals and hospital beds. At the same time, health care professionals have a responsibility to involve the patient in their care. This places high demands on health care professionals in surgical care. A good interaction in the team reduces the risk of errors being committed, and patient safety can thus be increased. Patient safety has been shown to increase with higher patient participation; therefore, it would be important to examine the possibilities of what we could be done to involve the patient and get over the obstacles that exist. Previous studies on patient participation have focussed on patients' perspectives in surgical care, but there is a gap of knowledge on participation and surgical staff perspective.

AIM

The aim of the study was to identify and describe health care personnel's view and behaviour towards patient involvement in surgical care.

Research questions:

1. What does patient involvement of health care professionals mean in surgical care?
2. What is the health care personnel's view and behaviour regarding patient involvement, and what do health care professionals think hinder patient involvement?

METHOD

Design

A quantitative cross-sectional study was carried out to answer the questions of the study. The study is a part of a larger project regarding patient involvement in surgical care, and earlier studies are published elsewhere (19, 20).

Sample and data collection

The inclusion criteria were physicians, registered nurses and practical nurses at a surgical clinic at a university hospital in southern Sweden, who were asked to participate and were recruited in spring 2018. The exclusion criteria were physiotherapists and temporary staff. Before the questionnaires were distributed, the staff was informed orally about the study at workplace meetings. The staff was also informed in writing through an information letter accompanying the questionnaire. Reminder e-mails were sent out in connection with the start of the study and when the data collection had been going on for a few weeks. The data collection was conducted in May 2018.

Questionnaire

A validated questionnaire was used in this study to describe the health care person's view and behaviour towards involvement in surgical care (21). The original questionnaire was developed to examine how the staff looked at the patient's participation during their time in hospital, during the acute phase, and on discharge and the ability of health care professionals to involve the patient in their care. The original questionnaire was designed in five phases.

The first four phases were literature review, focus group discussions, construction of the issues and a pilot study. The final phase of the questionnaire construction was a main study conducted to establish the validity and reliability of the questionnaire. The final version of the questionnaire consisted of 57 questions. The first seven questions are on demographic issues with four response options. The remaining questions in the questionnaire are grouped under the following areas: patient involvement, acute phase, hospital time, discharge phase and questions on employment and workplace.

All questions in the questionnaire are answered on a 4-point Likert scale (22). The grading is "Not at all" (1) to "To a very great degree" (4) or "Don't agree at all" (1) to "Agree completely" (4). The subscales of the questionnaire are patient involvement, information, patient needs, activity, motivation and hindrance. The questionnaire was reliability-tested by Arnetz et al. and showed a Cronbach's alpha value >0.7 (21). A reliability test of the internal consistency of the data in this study was conducted, which showed Cronbach's alpha over 0.7, and in three of the subscales, Cronbach's alpha was >0.8 .

Statistical analysis

Professional characteristics were summarized to compare differences between the three groups, and descriptive statistics were analysed. To test differences in the subscales between different professions, the non-parametric Kruskal-Wallis H test and ad hoc Mann-Whitney U test were used (23). The Kruskal-Wallis H differences among all professions were tested at the same time and when significant differences occurred, pairwise comparisons between the different professions were tested with the Mann-Whitney U test. The results of the Kruskal-Wallis H test are presented in a table in the results section, and the results of the Mann-Whitney U test are

presented in the text. When analysing subscales, the results are presented as the median values. Since all subscales have different maximum values, these medians are presented as percentages. Fisher's exact test was used to perform pairwise comparisons between the different professions on the answers of individual questions. The questions have four possible answers, and those answers have been dichotomized before analysis. The threshold of statistical significance was set at $p < 0.05$. The data in this study were handled in accordance with the authors' data processing of the questionnaire responses (21). Statistical analyses were conducted in IBM SPSS Statistics 25.

ETHICAL APPROVAL

The study has ethical approval from the regional ethics committee in Southeast Sweden (No: 2016/276-31). All staff who received the questionnaire were informed that participation was voluntary.

RESULTS

A total of 140 questionnaires were sent out, and 102 responded (response rate 73%). There were similar response rates and internal missing data between the three included professional groups. Table 1 presents the characteristics of the questionnaire respondents. Most of the nurses were women, and most of the physicians were men. There was much variation in how long the professionals had worked in their workplace. The majority of physicians and assistant nurses had more than ten years of professional experience, and the nurses had less than half that.

The response options were grouped into two categories, "fully aligned" or "fairly good" (positive factor) and "do not match" or "not at all" (negative factor). All participants stated that "patients receiving clear information" meant patient participation. "That the patient has primary responsibility for his or her future health" was graded lowest of the statements (Figure 1).

A strongly significant difference was seen between the professions in the subscale's information ($p = 0.002$) and motivation ($p = 0.001$). Significance was weaker in the subscale's activity ($p = 0.030$) and hindrance ($p = 0.030$). In other subscales, we observed no significant differences between the professions. In all subscales, physicians graded higher than nurses. No significant difference was observed between the registered nurses and the practical nurses ($p = 0.08$). Statistically significant differences existed between the professions in the subscale information. Physicians rated their information to a greater extent than did the registered nurses ($p = 0.005$) and the practical nurses ($p = 0.001$). In the subscale motivation, where the issues focused on motivating and involving patients, there was a strongly significant difference between the physicians' estimation and that of the registered nurses ($p = 0.006$) or the practical nurses ($p = 0.001$) (Table 2).

Table 3 presents the extent to which different professions informed patients about different activities. Providing information about physical activity was done to a large extent by all professions. Providing information about driving and sexual activity was done to a low degree. A minority of all participants informed patients about sexual activity. A majority of the physicians discussed returning to work with patients, unlike both nurse groups (Table 3).

Table 4 shows the rates at which the health professionals believed they were prevented from being able to talk to and provide support to patients. The results show that the majority considered that lack of time and prioritization of other tasks hindered their provision of support to the patients. The practical nurses responded that the patient's own unwillingness was an obstacle to patient involvement more often than registered nurses and doctors did. A minority of doctors answered that their own insecurity was a hindering factor.

The results showed significant differences in patient aversion to involvement between the answers of doctors and practical nurses ($p = 0.018$) as well as between the answers of registered nurses and practical nurses. There were also significant differences between doctors and practical nurses in the factor relatives ($p = 0.003$).

DISCUSSION

Health care professionals describe that they feel positively about patient involvement. Health care professionals surveyed consider clear information to be the most important factor for good patient involvement. Providing information and offering the possibility to ask questions align with the patients' wishes (19). Patients make their own important decisions in their care and express their own views and questions to health care professionals. Patient involvement increases the feeling of safety in patients (24, 25). Patients request increased involvement (26, 27), and so does nursing staff (16). To have continuous communication and information aims to meet the patient's needs (19).

Other studies describe patients' perspectives, and patients think that the information they receive in some cases is lacking (28, 29). Clear information is important, but patients often want more information. This can be explained by the health care staff overestimating their own ability to provide information, as well as adapting the information for the patient (29). However, it may also be because patients do not understand the information the health care professional gives them, which may be due to difficulties in taking in information or the patient's lack of understanding of the medical language used by staff (30).

To discuss what the patient can and cannot do after a surgical procedure is important for an optimal recovery process. Sexual activity is not discussed in most cases. This is consistent with previous research conducted in surgical care, where patients have not discussed with health care professionals what they can do sexually and how the surgery affects them sexually.¹⁹ Health care professionals describe sexual activity as a complicated topic to talk about. Previous research shows that clearer guidelines are needed to discuss sexual activity with patients (31).

In health care, it is important to maintain a high level of patient involvement, not only because of the responsibility of the health workforce but also because it can contribute to increased patient safety (32). In this study, it was noted that health professionals saw several areas that were deficient in the involvement of patients. Health care professionals reported lack of time as the main reason for not giving the patients enough information. This is supported by previous research in which the time aspect affected not only patient involvement but also health care. By having less time, health care professionals feel restricted and cannot go through everything that they want with the patient. This means that some things are skipped or forgotten when they give their patients information (7). Due to tasks perceived to be of higher priority, there is not enough time to involve patients. Working actively to make patients involved in their

own care is a new source of stress, both positive and negative. Developing routines in the workplace to involve patients in health care can help health care professionals reduce negative and increase positive effects of stress (33).

The demographic data in this study show that many of the professionals had more than 10 years of professional experience. Kolovos et al. stated that nurses with experience interact better with the patient than nurses with less than three years of experience (34). Less experienced nurses have more difficulty making the patient become involved (6). Individual care and ongoing information on treatment and the goals of health care create trust between patients and professionals and increases the patient's sense of involvement (20).

Professionals have knowledge of patient involvement, but there are obstacles to carrying it out and difficulties due to a lack of time and priority. Facilitating health care professionals and providing patients with support and guidelines for the involvement of patients is a problem that needs to be addressed at the management level. There is a willingness among health care managers to work on the patient perspective, but there is a lack of experience in patient involvement (35). In health care, patients meet practitioners of several professions. Ensuring that everyone in the team helps to involve the patient in the treatment and motivate the patient can lead to higher patient involvement. Continuous personalized information can contribute to increased patient participation (19), and the concept relies on three caring science concepts; learning, caring relationship and reciprocity (36). But it seemed to be a challenge how these could be achieved in the clinical practice.

Methodological considerations

The present study contains both methodological strengths and weaknesses. The study used a questionnaire designed by Arnetz et al (21), contained 57 questions. A total Cronbach's alpha >0.7 (and in three of the subscales >0.8) is seen as a strength and a sign of high internal consistency. Because the study was conducted only in one clinic, this could have a negative impact on the external validity of the study results.

The results of this study are based on the questions in the questionnaire that aimed to address the study's purpose and research questions. The response rate was 73%, which seen as a strength. However, it is also a limitation that we do not provide reasons for the non-responders who may not care about patient participation and might have biased the results. All the questions in the questionnaire were answered on a 4-point Likert scale, and the staff graded how well they agreed with each question. This type of survey and response options investigate attitudes and views. The scale used in this survey makes it possible to identify positive and negative responses. The questionnaire's grading was 4 points, which meant that a dichotomizing of positive and negative answers could be analysed and presented in the results.

The questionnaire contained six subscales: patient involvement, information, patient needs, activity, motivation and hindrances. All the subscales were relevant to the purpose of the study and are considered to strengthen the validity of the study. The questionnaire was made up of questions for which the respondents carried out a valuation. When valuation questions are used, the participants are likely to overestimate their ability. It is a strength that the three different professions responded to the questionnaire and that all groups were relatively evenly

distributed in sample size. The sample included different sexes, ages and active work years, which can also be a study strength.

CONCLUSION

Health care professionals in surgical care rate the provision of clear information to the patients as the most important factor for patient involvement in their own care. Health care professionals think that patient participation in important decisions, given the opportunity to express their views and asking questions, are very important for patient involvement. Barriers for health care professionals to support patient participation are lack of time and prioritization of other work activities.

CLINICAL IMPLICATIONS

Health professionals have knowledge of patient involvement, but there are hindrances to it in clinical practice. Time constraints and other priorities can be common obstacles. Supporting health professionals and developing guidelines for improved patient involvement need to be created at the management level to create good conditions for stimulating patient involvement in surgical care.

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TABLES

Table 1. Characteristics of questionnaire respondents (n = 102)

	Physician n (%) n = 24 (23.5)	Registered Nurse n (%) n = 38 (37.3)	Practical Nurse n (%) n = 40 (39.2)
Sex			
Female	6 (25.0)	27 (71.1)	32 (80.0)
Male	18 (75.0)	11 (28.9)	8 (20.0)
Age			
≤ 29 years old	0 (0.0)	16 (42.1)	10 (25.0)
30-39	8 (33.3)	10 (26.3)	4 (10.0)
40-49	6 (25.0)	8 (21.1)	8 (20.0)
50-59	9 (37.5)	1 (2.6)	15 (37.5)
≥ 60	1 (4.2)	3 (7.9)	3 (7.5)
Years in the profession			
0-1 years	0 (0.0)	3 (7.9)	1 (2.5)
1-5	1 (4.2)	8 (21.1)	11 (27.5)
5-10	6 (25.0)	10 (26.3)	5 (12.5)
10-15	4 (16.7)	4 (10.5)	4 (10.0)
≥ 15	13 (54.1)	13 (34.2)	19 (47.5)
Years in the workplace			
0-1 years	2 (8.3)	11 (28.9)	12 (30.0)
1-5	10 (41.7)	13 (34.2)	16 (40.0)
5-10	1 (4.2)	2 (5.3)	0 (0.0)
10-15	5 (20.8)	4 (10.5)	7 (17.5)
≥ 15	6 (25.0)	8 (21.1)	5 (12.5)

Table 2. Staff ratings of subscales: comparison between professions

Subscale	All respondents Median %	Physician Median %	Registered Nurse Median %	Practical Nurse Median %	p-value
Patient involvement (n = 97)	91.7	95.8	91.7	95.8	ns
Information (n = 88)	85.0	90.0	80.0	75.0	0.002
Patient needs (n = 94)	81.3	87.5	81.3	81.3	ns
Activity (n = 95)	58.3	66.7	54.1	58.3	0.030
Motivation (n = 95)	70.8	87.5	70.8	54.1	0.001
Hindrance (n = 92)	41.7	41.7	41.7	41.7	ns

p-value < 0.05 = statistically significant, ns = non-statistically significant (Kruskal-Wallis H test)

Table 3. Proportion of respondents who. to a very or fairly large extent. discussed with patients the following everyday activities

	All respondents		Physician		Registered Nurse		Practical Nurse		Physician vs. Registered Nurse	Physician vs. Practical Nurse	Registered Nurse vs. Practical Nurse
	%	n	%	n	%	n	%	n	p-value	p-value	p-value
Physical activity	83.3	96	100	24	77.1	35	78.4	37	0.016	0.018	ns
Driving	25.8	97	33.3	24	16.7	36	29.7	37	ns	ns	ns
Sexual activity	13.4	97	20.8	24	11.1	36	10.8	37	ns	ns	ns
Housework	44.9	98	45.8	24	38.9	36	50.0	38	ns	ns	ns
Gardening	39.8	98	41.7	24	36.1	36	42.1	38	ns	ns	ns
Return to work	47.4	97	87.5	24	41.7	36	27.0	37	< 0.001	< 0.001	ns

n = number, p-value < 0.05 = statistically significant, ns = non-statistically significant, pairwise comparisons between professions

(Fisher's exact test)

Table 4. Proportions of respondents who either partially or to a high degree considered that the following factors prevent the possibility of conversing/supporting patients

	All respondents		Physician		Registered Nurse		Practical Nurse		Physician vs. Registered Nurse	Physician vs. Practical Nurse	Registered Nurse vs. Practical Nurse
	%	n	%	n	%	n	%	n	p-value	p-value	p-value
Lack of time	92.9	98	91.7	24	97.3	35	89.2	37	ns	ns	ns
Prioritizing other tasks	93.9	99	91.7	24	100	36	89.5	37	ns	ns	ns
Patient does not want	32.3	99	25.0	24	10.8	36	57.9	37	ns	0.018	< 0.001
Own uncertainty	25.3	99	8.3	24	24.3	36	36.8	38	ns	0.017	ns
Culture	58.2	98	54.2	24	55.6	36	63.2	38	ns	ns	ns
Relatives	37.5	96	16.7	24	33.3	36	55.6	37	ns	0.003	ns

n = number, p-value < 0.05 = statistically significant, ns = non-statistically significant, pairwise comparisons between professions

(Fisher's exact test)

FIGURE LEGENDS

Figure 1. What does patient participation mean to you? (n = 99). Presented in proportions (%).

- Healthcare professionals agree that the statement is related to the concept of patient participation
- Healthcare professionals don't agree that the statement is related to the concept of patient participation