


Where Does the Patient Fit? An Analysis of Word Use Within the Context of Interprofessional Collaborative Care

Global Qualitative Nursing Research
Volume 6: 1–7
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DOI: 10.1177/2333393619889353
journals.sagepub.com/home/gqn


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Abstract

Patient-centeredness is considered central to interprofessional collaborative patient care as a participatory, partnered approach between health care professionals and patients. Content analysis of 501 articles from the 1986, 1987, 1988, 1996, 2006, 2013, 2014, and 2018 volumes of a selected journal was undertaken. The purposes were to identify contexts in which the term patient was used in articles with a primary focus on interprofessional care and to identify trends in its usage. With Dilthey's ideas on language as a framework, patient and its variations in the articles were coded under five categories. Findings suggest that the term patient appears predominantly as a modifier for activities enacted by experts and a platform for the discussion of relationships among professionals. There is limited evidence that use of the term patient fits within the context of partnership, suggesting that the language in published interprofessional collaborative research and discussion is currently largely expert, not patient-centered.

Keywords

content analysis, interprofessional collaboration, patient-centered care, qualitative research, interprofessional care

Received February 21, 2019; revised October 17, 2019; accepted October 24, 2019

The coining of the term patient-centeredness in the late 1960s challenged the dominance of medicine in decisions related to patients (Bleakley, 2013). Patient-centered care can be defined as a collaborative, bidirectional relationship between health professionals and the patient that intentionally involves the patient in decisions throughout treatment and care (Brummel-Smith et al., 2016; Clauser et al., 2015; Körner et al., 2018). This relationship has been identified as integral to quality and continuity in care (Brummel-Smith et al., 2016).

The inclusion of patients and families in all aspects of care delivery and in decisions related to their care is considered fundamental to health care teams (Clark, 2014; Clauser et al., 2015; Prentice et al., 2015; Sidani & Fox, 2014) and is emphasized in various policy documents in countries such as Australia, Canada, Germany, the United Kingdom, and the United States (Scholl et al., 2014). The central position of the patient as a driving force in decisions related to care (Baker et al., 2011; Brummel-Smith et al., 2016; Charon, 2012; Clark, 2014; Hall et al., 2014) and in interprofessional collaborative teams is reflected directly, for example, in two of the domains in the Canadian National Interprofessional Framework: Patient/client/family/community-centered care and interprofessional communication (Health Canada, 2010). The domain of patient/client/family/community-centered

specifically references this concept of patient-centeredness and intentional partnership between health care professionals and the patient. Despite the inclusion of patient-centeredness, competency language within the domain, such as the importance of supporting, sharing information, listening respectfully, and educating patients and families (Health Canada, 2010), suggests that the role of the patient is perhaps more receptive and passive than one of the agencies. Competency statements within the domain of interprofessional communication indicate that professionals are to establish trusting relationships with patients. The inclusion of the patient in the health care team is directly indicated in statements such as “actively listen to other team members including patients/clients/families” (Health Canada, 2010, p. III). Other domains, such as collaborative leadership and team functioning, include no direct reference to patients/clients/families, which could imply that the role of the patient is somewhat limited.

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The movement toward patient-centered care and interprofessional collaborative care represents a fundamental shift in dominant thinking within the health care system (Vestergaard & Nørgaard, 2018). Within this shift, it is assumed that the uniqueness of the experiences and values of the patient, including those related to nonmedical aspects of the patient's life, must be understood by the interprofessional team (Scholl et al., 2014). To establish this deep understanding, relationship and reciprocity, by necessity, become the foundation of patient-centered interprofessional collaborative care (Moore, 2019; Suchman, 2006). This also includes the belief that choice, discovery of a common narrative, and shared power (Sidani & Fox, 2014) to the extent and in the manner that the patient finds appropriate (Brummel-Smith et al., 2016) are important.

The paradigm of relation (Hall et al., 2014; Suchman, 2006) assumes that outcomes are maximized when relationships in health care, whether among health care professionals or among health care professionals and patients, involve connectedness with others, who contribute actively to decisions. Diversity and openness to other ideas and experiences are seen to contribute to outcomes rather than to be a threat to the control of the expert (Suchman, 2006). Vertical hierarchies in which everyone, including the patient, know their place, are replaced by what Bleakley (2013) terms "horizontal collaboration" (p. 27) and trust in which patients are assumed to be the "primary makers of values, meanings, and decisions in their own lives" (Suchman, 2006, p. 8). By contrast, the traditional control paradigm is predicated on hierarchy. Within this hierarchy, health care experts and perhaps most often the physician (Bleakley, 2013; Price et al., 2014; Szafran et al., 2019) assume overall responsibility for decisions related to the patient because of greater expertise, social status, education, and subsequent mastery of knowledge (Suchman, 2006). Care is medically, rather than patient-centered, and care is performed on, rather than with, the patient. Although, by definition, the patient is at the center of interprofessional collaborative patient care, there are, however, conflicting evidence and opinions as to whether the patient is indeed the center because of the continued dominance of the paradigm of control and hierarchy (D'Amour & Oanadasan, 2005; Suchman, 2006).

Paradis and Reeves (2013), in a review and coding of interprofessional articles in PubMed between 1970 and 2010, suggested that there is declining interest in studies and articles in interprofessional care related to health care professionals and groups. There is, however, increasing interest in patient advocacy and patient-centered care, foundational elements of interprofessional collaboration. Brummel-Smith et al. (2016), through their findings, suggested that despite the intentions of interprofessional care such as support of decision making and autonomy, there are still significant barriers to patient-centered care. These include concerns about risk and safety when patient decisions place the patient at risk of death or worsening health, lack of coordinated communication among health care settings, and health professional

dominated decision making. Webster et al. (2013) suggest that system- and provider-level barriers ignore individual patient experience and thus limit involvement in treatment decisions, perhaps related to differing priorities and needs in care between health care professionals and patients. Patients in the study by Körner et al. (2013) voiced a need for more respect and greater involvement in decision making, whereas health care professionals emphasized aspects of their own professional team relationships such as conflict management and how to work with difficult team members. Focus groups with expert practitioners in chronic care in New Zealand suggested that a shift fully toward shared decision making and patient-centered care in interprofessional collaborative care has not yet occurred, with health care professionals either needing further skill development in this area or fearing that their own power and status would be diminished (Fouche et al., 2014). These findings again reinforce the idea that patients occupy a subordinate role to the concerns of health care professionals.

One of the difficulties in determining whether patient-centered care (and thus, if the patient and not professional and governmental interests) is foremost in the movement toward interprofessional care and education is our imprecise and vague conceptualizations of patient-centered care (Cheng et al., 2016; Sidani & Fox, 2014). This presents challenges in discerning whether the involvement of the patient is an incidental inclusion in different relationships among health care professionals or whether the patient relationship is the focus of the other relationships. This also contributes to difficulties in determining whether patient-centered care has had positive outcomes.

The use of terms and language to describe social processes such as interprofessional collaboration, in which patient-centeredness is assumed to be embedded, is important, both in its influence on what we think we are doing and in how it reflects what we may be doing in practice. Wilhem Dilthey, the noted German hermeneutic philosopher and historian, suggested that language or words influence, reflect, and communicate social and cultural structures (Bulhof, 1976, 1980).

In their written form, such as in manuscripts and articles, words can be enduring and observed by others. Thus, language involves not only words, which express individual and collective consciousness, but also interpretation, which reflects how words are understood within cultures. To fully grasp the intention of text or to interpret it, words need to be considered within the totality or context of the text and then related back to the culture or from where the text originates. In doing so, Dilthey proposes that it is possible to understand connections between the past and present (Bulhof, 1976, 1980; Dilthey, 1985a, 1985b), which is helpful in the consideration of trends and, in this content analysis, how words such as patient are considered within the context of interprofessional collaborative patient care, both within the current context and that of the past.

Table 1. Prevalence of Codes in Each Journal Volume (Year) by Number and Percentage.

Year	Patient as Neutral or Empty Term (PAN)	Patient as Descriptor (PAD)	Patient as Recipient of Care (PRC)	Concept Development of Patient Partnership (CDP)	Patient as Partner (PAP)	No Use	Total Articles
1986	5 (18%)	1 (4%)	15 (54%)	2 (7%)	2 (7%)	3 (11%)	28
1987	2 (8%)	1 (4%)	17 (68%)	2 (8%)	1 (4%)	2 (8%)	25
1988	15 (44%)	0	15 (44%)	1 (3%)	0	3 (9%)	34
1996	0	15 (78%)	4 (18%)	0	0	3 (14%)	22
2006	22 (34%)	9 (14%)	22 (34%)	3 (5%)	3 (5%)	5 (8%)	64
2013	4 (4%)	61 (58%)	23 (22%)	2 (2%)	5 (5%)	11 (10%)	106
2014	4 (4%)	62 (56%)	27 (25%)	1 (1%)	6 (5%)	10 (9%)	110
2018	212 (7%)	1,480 (46%)	1,394 (43%)	7 (0.2%)	158 (5%)	3 (0.9%)	112
Total	264	1,629	1,517	18	175	40	501

To understand how patient-centeredness has evolved and to determine whether it is indeed present in interprofessional collaborative care, a content analysis of articles in a selected journal was undertaken. The *Journal of Interprofessional Care*, which publishes articles that represent a broad range of settings in health care and education and the perspectives of various professionals, was selected because of its focus on interprofessional education and practice. The purposes of this content analysis were to (a) identify the contexts in which the word patient was used in articles with a primary focus on interprofessional care and (b) identify trends in the usage of the word patient within articles focused on interprofessional care.

Method

The authors searched all articles within each issue in the selected journal for the years 1986, 1987, 1988, 1996, 2006, 2013, 2014, and 2018. The choice of years was guided by feasibility and the intent to include a timespan that was representative of the evolution of concepts and practice in interprofessional patient care. The 1986 to 1988 volumes of the journal were aligned with the journal's inception in which early thinking and publication in interprofessional care was represented. The 1996 and 2006 volumes were chosen as midpoints in thinking around interprofessional care and collaboration and the 2013, 2014, and 2018 volumes as recent artifacts of thinking in collaborative interprofessional care, with the 2018 volume representative of the most current full set of issues available.

As the term patient was assumed operationally to mean any person or group that required health care, all journal issues from the selected volumes were searched for the related terms of *patient*, *client*, *consumer*, *family*, *community*, and *population*. The initial search suggested other relevant terms, and the articles were searched again for any terms related to the operational definition such as *resident*, *elderly*, *adult*, *child*, *adolescent*, *student*, *user*, and *prisoner*, as well as for any other reference to patient or its variations. All articles from the selected volumes were included in the

analysis¹ because the purposes of the study were to explore the contexts and trends in how the word patient was used in interprofessional care, which would include nonuse of the word patient or its variations. Within the study, context only referred to how the word patient was used and did not include consideration of the care setting, type of study, or quality of research.

There were 501 articles retrieved for the content analysis, with book reviews, and reference lists excluded from the analysis. Each article was read initially by one of the three authors to determine how the word patient or its variations were used within the article. Notations were made as to when and how the term *patient* was referenced. Frequency counts for the number of times the word patient appeared in each article were also performed. This information was entered in a matrix format for comparison purposes. Each author independently reviewed the matrix and then all the authors met several times as a group to compare usages and contexts for the term patient. Through an iterative process that involved consensus and inductive analysis, the authors clustered word usages and contexts that shared similar elements into key codes that represented the main contexts in which the term patient was used. The articles in each volume were then reviewed a second time by the same researcher. Through deductive analysis, the codes were assigned to each use of the term patient in the articles, the codes were counted, and the most prevalent code in each paper was then determined (see Table 1). The data were then summarized by the most prevalent code across issues and then by volumes to evaluate trends in *how* the term patient was being used.

Any discrepancies in coding were discussed with the team, and the team compared the specific articles in which discrepancies were identified against the codes to reach a decision. Data were then summarized across each volume into the mean frequency of the use of the word patient in each article (Table 1). Similarly, the data were summarized by the most prevalent code per paper and across issues and then by volumes to evaluate trends in *how* the term patient was being used.

Findings

Final Key Codes for Analysis

Five key codes were developed from the first review of the articles. These codes represented the relationship between the word patient and how it was being referenced in the articles.

Patient as neutral or empty word (PAN). This code emerged from use of the term patient without any clear context or meaning. Within this usage, the term patient appeared without grounding as a descriptor, recipient of care, or partner, and was used with limited frequency within an article. The primary aim of these articles was the discussion of specified disorders or activities, such as educational strategies or funding. For example, in one article, simulation for educational purposes was described and although the scenario focused on a patient situation, the purpose of the article was to describe the interactions among interprofessional team members, with no further significant reference to the patient involved. In another, funding issues related to health care were discussed, with the only reference to patients being that they were a source of funding.

In the articles where this code was predominant, the term patient was used with limited frequency and became an incidental word that was not firmly anchored to the purpose of the article or to the concept of persons who required health care. Although not anchored to consideration of the patient in any significant way, the focus of these articles was nonetheless interprofessional collaboration, which, at least in some regions of health care, is assumed to include the patient in some way. The lack of clear grounding in patient interests could be construed as problematic, if assumptions regarding the importance of patient-centeredness to positive care outcomes and by implication, the need to consider patient interests, are valid. Of the issues analyzed, the highest frequency for this code occurred in the 2018 issues—the lowest frequency for the PAN code in the 1996 volume, where it was not used at all.

Patient as descriptor (PAD). Within this context, the term patient was used as descriptor or adjective in phrases such as patient safety, patient management, patient care, patient outcomes, patient-centeredness, patient services, and patient advocacy, with patient safety, patient management, patient outcomes, and patient care being the predominant phrasing. Within this code, there was little or no reference to partnership or collaboration with the patient. Although the phrases obviously referred to the patient, the use of the term patient was more clearly tied to roles or activities that the health care professionals involved in interprofessional care might assume either separately within their disciplines or as an interprofessional team. For example, in one article, related to training of health care professionals, frequent reference was

made to patient knowledge. In this context, the term patient was predominantly used as an adjective without consideration of the patient as a recipient of care or as a partner.

As shown in Table 1, PAD had the highest frequency of use cumulatively and across volumes, except for the 1986, 1987, 1988, and 2006 volumes. Notably, the frequency of use of PAD was highest in the most recent volumes (2013, 2014, and 2018) of the journal.

Patient as recipient of care (PRC). This code emerged from articles in which specific care interventions were applied directly to patients and in which interprofessional collaboration or relationships were at least a consideration in the intervention. Interventions encompassed a variety of considerations, which included “physical, cognitive, emotional, social, and spiritual domains of health” (Sidani & Fox, 2014, p. 139) that are associated, at least in part, with holistic care and a diversity of settings. Considerable attention may have been given in these articles to how interprofessional relationships might be operationalized to achieve the outcomes desired in the intervention. There was, however, limited or no discussion of how the patient might be involved in identification of needs, collaboration around desired outcomes, or how the patient might work together with health care professionals to achieve the identified interventions. In one article, for example, it was suggested that it was up to the physician or the health care team to find out which approach might be best for a patient, implying that the patient had little or no input into decisions concerning care.

In the volumes from the 1980s, it was noted that the articles in the journal focused on holistic care, and within this context, it was found that approximately 44% to 68% (see Table 1) of the usage of the term patient fell under the PRC code or within the context of care provision. In the 2018 volume, the frequency of the PRC code is increased by comparison with the previous volumes, and overall, PRC is the second most frequently occurring code.

Patient as partner (PAP). Within this context, the patient was discussed as a partner or collaborator in care from an empirical perspective in which partnership with the patient, family, or community was enacted in some way. Articles in which the patient as partner appeared described the outcomes of projects or studies in which the patient was intentionally involved as an active collaborator, rather than as the recipient of care or as a peripheral member of the treatment team. An article in which this code was predominant included one in which there was active, deliberative, and intentional dialogue between patients and health care professionals to discuss current methods of care and the development of services to ensure that services benefited patient users. Cumulatively, the code PAP had the second lowest frequency of occurrence.

Concept development of patient partnership (CDP). This code was used to capture references to the patient as partner or collaborator in which patient-centered care and patient partnership were explored conceptually in relation to meaning, interpretation, and philosophy. For example, articles in which this code was prevalent might discuss the concept of patient empowerment or centeredness and its theoretical underpinnings or the value of including the values, priorities, and beliefs of the patient in care decisions. CDP had the lowest cumulative frequency of occurrence across all years; notably, the highest frequency of CDP occurred in the year 2018.

Discussion

Findings from this content analysis suggest that the term patient and its variations are included in most, but not all, of the articles published in selected volumes of the journal under study from 1986 to 2018. The frequency of use of the term patient and its variations is outwardly suggestive of an emphasis on the patient in interprofessional care. This supports the findings of Paradis and Reeves (2013), who observed that there was an increase in the use of patient in titles of interprofessional articles, a finding that they suggested is indicative of a greater focus on patient advocacy and patient-centeredness. Without consideration of the word patient in relation to its context within articles, it could be concluded that the intent and practice of interprofessional collaboration is tied closely to patients. Furthermore, it would suggest that the patient, if not the central concern of interprofessional collaboration, is clearly an important element in collaborative, interprofessional practice.

When, as Dilthey suggests, word and context are combined (Bulhof, 1976, 1980), the findings from this content analysis raise questions about the role that patients continue to occupy in collaborative, interprofessional care. In the volumes from the 1980s, it was noted that the articles in the journal focused on holistic care. Within this context, it was found that most of the usage of the term patient fell under the PRC code or within the context of care provision. The code, PRC, continues as a somewhat diminished but common context for patient care in articles from 1996 and onward, suggesting that the patient is a central concern in at least the delivery of interprofessional collaborative care. While it can be argued that interventions directed toward patients and their well-being are holistic in that attention is focused on the needs of patients, this usage of the term patient tends to involve interprofessional activity that is unidirectional, meaning that professionals are giving care *to* a patient or considering how to best give care. Responsibility for decision making tends to fall within the professional or organizational relationships rather than in partnership with the patient.

What is particularly significant in findings is that the usage of the term patient predominantly falls under the PAD

code, especially in articles from the later volumes. Within this context, the term patient is used as a modifier for nouns such as safety, management, or education, a finding that was also noted in a review of the concept of patient-centered care in literature specific to physiotherapy (Cheng et al., 2016). While nouns such as safety are associated with and important for patients, the shift in the prevalence of the PRC code in articles up to and including 2006 volumes to a prevalence of the PAD code suggests a shift in collaborative care from an emphasis on the patient to one on the professional. The context here is professional-centered. Activities and interests of nurses, doctors, and other professionals are described in articles and how these relationships can be facilitated within these activities and interests, rather than relationships with patients. In these articles, the usage of the term patient tended to position care delivery and patient management as platforms for exploration of the processes and relationships among professionals. Essentially, as written, these articles became professional or expert, rather than patient-centered, and focused on what is or should be occurring in relationships among health care professionals from various disciplines.

The increased use of the term patient, especially in the later volumes, is consistent with the findings by Paradis and Reeves (2013) in their analysis of the titles of interprofessional articles between 1970 and 2010. Nonetheless, the findings of this current study, which explores the context of the usage of the term patient, suggest that there has been and continues to be a tendency to use the words patient and patient care for introspective explorations about relationships among experts, a finding that is echoed in the study by Körner et al. (2013). If observable artifacts such as words and articles can be said to reflect culture, then these findings point to a culture in which there are continuing challenges with how, when, and where to fully involve the patient as a partner. This concern was expressed over a decade ago by writers such as D'Amour and Oanadasan (2005) and Suchman (2006). More recently, it has been raised in other studies that have explored the operationalization of patient-centered care (Fouche et al., 2014; Kitson et al., 2013; Körner et al., 2013) and is a concern that Cuff et al. (2014) suggest must be considered with some urgency. The findings in this current study also suggest that a greater gap has been potentially created between professional and patient interests, rather than the achievement of care that is focused on the patient or patient-centered.

A second significant observation in this content analysis was the codes that are most suggestive of collaboration or partnership with patients, PAP and CDP, were least predominant in terms of frequency of occurrence in articles throughout the years that were analyzed. In 1988 and 1996, there were no articles in which codes that framed the context of patient partnership were predominant. In 2018, however, an increase was noted in occurrence of the PAP code, which may merit ongoing attention.

The relative lack of consideration given to the patient as partner suggests that partnership with patients continues to be an espoused value that is either not well articulated or enacted in interprofessional collaborative care. Perhaps this reflects, as West et al. (2005) suggest, the difficulty in achieving patient-centered care within systemic constraints such as heavy workloads and lack of resources. Lack of reference to enactment of partnership may also reflect to what Sidani and Fox (2014) allude as a difference between patient-centered care and patient-centered collaborative care, with the former being concerned with the needs of the patient, but not necessarily involved in partnership of care, which is suggested by involvement of the patient as a full partner in the interprofessional team.

Perhaps of even more concern is that the findings suggest that the patient is missing altogether in some articles about interprofessional care, a lack that is significant, given that major initiatives such as the Triple Aim, the work of the Institute of Medicine, and the Francis Report in the United Kingdom all emphasize the need to put the patient at the center of health care. By implication, these initiatives have placed the patient at the center of interprofessional collaboration, which is seen as a vehicle to address the fragmentation that enables loss of effective, safe care (Berwick et al., 2008; Brandt, 2014; Brummel-Smith et al., 2016; Reeves et al., 2014).

Despite the conclusions drawn, there were several limitations to this analysis of literature and language. One major limitation is that the conclusions may not necessarily represent what occurs in practice, where patient partnership may be far more prevalent. Nonetheless, research is influential in shaping practice decisions and to the extent that language reflects how we think and practice, findings of limited patient partnership in the literature related to research and practice innovations should not be overlooked. A second limitation is found in the sampling and summarizing methods. As stated, once the codes were established, the coding categories were summarized to the most prevalent code per article. By doing so, the context of word usage reflected the overall aim of the article, and thus nuances such as minor references to the patient as a partner may have been lost. An additional, potential limitation is that the volumes not selected for content analysis may have yielded differing results. To mitigate this possibility, the authors sampled from volumes across the life span of the journal.

Conclusion

If, according to Dilthey, language reflects what we do and what we mean within social and cultural groups (Bulhof, 1976, 1980), the findings of this content analysis point to a continuing lack of clarity about the role and inclusion of patients as partners and as the center of collaborative, interprofessional care. The findings also highlight the introspectiveness of interprofessional care and its tendency perhaps to remain professional, and thus expert-centered rather than

patient-centered. If the aim of interprofessional collaboration is to make patients the center of care and, in so doing, to improve patient outcomes, then there is need, as Brandt et al. (2014) suggest, to openly examine the current state of the field. Without a clear sense of where and how the patient fits within patient-centered interprofessional care, it is difficult to measure whether this aim and its accompanying outcomes have been met.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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Note

1. Titles and names of authors of the articles selected for analysis are available upon request.

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