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LA COMUNICACIÓN COMO ELEMENTO FUNDAMENTAL EN LA LITERATURA ESPECIALIZADA EN EXPERIENCIA DE PACIENTE (1989-2013)

Communication as a fundamental element of patient experience literature (1989-2013)

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Resumen

A nivel conceptual, la "experiencia de paciente" comparte varios elementos definitorios con el concepto de comunicación, como la interacción, las relaciones, la información, la reputación o el *engagement*. En este sentido, el objetivo de nuestro estudio es la identificación de la frecuencia absoluta de la aparición del concepto comunicación y su entorno semántico en 40 artículos representativos del ámbito de la experiencia del paciente previos a la definición de consenso facilitada por The Beryl Institute (2014), así como la asociación del concepto comunicación con resultados clínicos, estableciendo como referencia para la muestra de artículos el trabajo de Doyle, Lennox y Bell (2013). Mediante análisis de contenido, observamos la presencia generalizada de la comunicación de forma directa o indirecta. Concretamente, el término "comunicación" aparece en 29 casos, el término "información" en 25, "relación" en 21 e "interacción" en 21. También se concluye que la comunicación es necesaria para utilizar cualquiera de las herramientas de medición de la experiencia de paciente y que la mayoría de intervenciones en las que interviene la comunicación tiene asociaciones positivas con los resultados clínicos.

Palabras clave: Comunicación de la salud; Experiencia de paciente; Interacciones; Resultados clínicos.

Abstract

At a conceptual level, "patient experience" shares several defining elements with the concept of communication, such as interaction, relationships, information, reputation or engagement. In this sense, the objective of our study is to identify the absolute frequency of the appearance of the communication concept and its semantic environment in 40 representative articles from the field of patient experience prior to the consensus definition provided by The Beryl Institute (2014), as well as the association of the communication concept with clinical results, establishing the work of Doyle, Lennox and Bell (2013) as a reference for the sample of articles. Through content analysis, we observe the widespread presence of communication directly or indirectly. Specifically, the term "communication" appears in 29 cases, the term "information" in 25, "relationship" in 21 and "interaction" in 21. It is also concluded that communication is necessary to use any of the tools for measuring the patient experience and that most interventions involving communication have positive associations with clinical outcomes.

Keywords: Clinical results, Health Communication, Interactions, Patient experience.

1. INTRODUCTION

Patient experience, which has conquered the centre of healthcare in recent times (Salomon, 2014), is progressively moving away from the field of biomedicine to encompass a multidisciplinary area in which interaction, relationships, information, communication, reputation, expectations or engagement, terms that appear in different definitions of the concept collected by Wolf et al (2014) and which transfer the leading role to the social sciences.

Along these lines, there is a tendency to relate the communication capacity of healthcare and non-healthcare professionals with patients to the fact that the latter comply with doctors' recommendations, improve the self-management of their chronic pathologies and adopt preventive behaviours (Institute for Healthcare Communication, 2011). Studies over the past three decades show that health professionals' ability to explain, listen and empathise with patients can have a profound effect on their biological and functional health outcomes, as well as on patient satisfaction and the experience of care.

1.1. Patient experience approaches

In its origins, patient experience was presented as a responsiveness to patients to be encountered in domains of autonomy, choice, communication, confidentiality, dignity, prompt care and quality of basic services (Bleich, Ozaltin and Murray, 2009).

For Feirn, Betts and Tribble (2009), patient experience is grounded in the quality and value of all interactions, direct and indirect, clinical and non-clinical, spanning the entire duration of the patient/provider relationship. While for Weiss and Tyink (2009), the concept was based on the components of a patient-centred culture that encompasses high quality and competent care, personalised care, timely responses, care coordination, and a reliable and responsive response.

Robison (2010) speaks of an 'ideal experience', created by meeting four basic emotional needs - trust, integrity, pride and passion - and engaging patients. Emotional bonding is also developed by Needham BR. (2012), when he refers to the patient experience as managing the emotional and physical roller coaster a patient experiences while undergoing a healthcare procedure and maximising the patient's health and social, mental and physical well-being. To support this effort, the author suggested personalising medicine, partnering with patients and empowering employees.

Meanwhile, Stempniak (2013) marks the beginning and end of the patient experience from the first phone call to discharge, and includes the reduction of distress and anxiety across the continuum of care. While Bowling et al. (2012) focus on the management of patients' expectations based on direct, personal observations of their care. Expectations include cleanliness, information about where to go, convenient and timely appointments, being seen on time, choice of hospital/doctor, reception staff, being well informed, clear and easy to understand, being involved in treatment and decision making, that you experience a reduction in symptoms/health problems, that the doctor is respectful and treats you with dignity, that you are reassured, that you receive advice about your health and condition, that you are informed about the cause and management of your illness and the benefits/side effects of treatment, and that you have the opportunity to discuss your problems.

In the same vein, Frampton (2012) reduces patient experience to two areas that contain the expectations of Bowling et al. (2012): 1) human interactions and 2) the environment of care. He further suggests that patient-centred care lives between the care and treatment provided and how it is experienced by patients and their loved ones.

Pemberton and Richardson (2013) provide a view of the patient experience framed by a series of six active steps, including: reputation, arrival, contract, stay, treatment and post-stay. The authors also suggest the importance of staff culture and engagement in driving an effective patient experience effort, in a similar way to Staniszewska et al. (2014), who set out seven key generic themes for achieving a high-quality patient experience: treating the patient as an active participant; responsiveness of services; an individualised approach; lived experience; continuity of care; and relationships, communication, information and support.

On the other hand, Hewitson et al. (2014) argue that experience is described as patients' self-reports of their experience of hospital care, including patient-professional interactions, provision of information, involvement in decisions and support for self-care, and overall ratings of care.

This is but a small compilation that ends in 2014, coinciding with the publication of The Beryl Institute's[2] (2014) consensus definition that presents patient experience as "the sum of all interactions, shaped by an organisation's culture, that influence patient perceptions, across the continuum of care". This definition contains four pillars in which we can identify many of the elements raised by the authors discussed above: Interactions, culture, perceptions and continuum of care.

The Beryl Institute (2014) refers to the orchestrated touch points of people, processes, policies, communications, actions and environment with the concept of interactions introduced in its definition. Feirn, Betts and Tribble (2009) specify interactions as "direct and indirect, clinical and non-clinical". Frampton (2012) includes an adjective 'human interactions', while Hewitson et al. (2014) specify 'patient-professional interactions', but also specify 'provision of information, participation in decisions and support for self-care' that require interaction. On this pillar, and acting as synonyms for interaction, all the "domains" (Bleich, Ozaltin and Murray, 2009), "care" (Weiss and Tyink, 2009), "engaging the patient" (Robison, 2010) - which requires interaction - are sustained, 'submitting' and 'experiencing' (Needham, 2012), 'engaging' (Bowling et al., 2012), 'active patient steps' (Pemberton and Richardson, 2013), 'active patient' and 'relationships, communication, information and support' (Staniszewska et al., 2014).

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[2] The Beryl Institute is the global community of practice dedicated to improving patient experience through collaboration and knowledge sharing. In 2014 it defined patient experience as the sum of all interactions, shaped by an organisation's culture, that influence patient perceptions across the continuum of care.

Culture included in The Beryl Institute's definition refers to vision, values, people (at all levels and in all parts of the organisation) and community. While many of the definitions implicitly include some of these elements, only two include it explicitly: Weiss and Tyink (2009) refer to "patient-centred culture", and Pemberton and Richardson (2013) include "staff culture and engagement".

Perceptions understood as what patients and supporters recognise, understand and remember go largely unnoticed in most definitions. Bowling et al. (2012) introduce the concept of "expectations", Staniszewska et al. (2014) put forward "lived" experience, and we want to emphasise the term "lived" as an element of recall, which is along the same lines as Hewitson et al. (2014), who from a more practical perspective put forward "patients' self-reports of their experience of care", including "overall ratings of care".

The Beryl Institute refers to the moments before, during and after the provision of care when they include "continuum of care" in their definition. This continuum is explicitly presented by Feirn, Betts and Tribble (2009), when they refer to "the entire duration of the patient/provider relationship". Also Stempniak (2013), when he speaks of "continuum of care", or Staniszewska et al. (2014), when they state "continuity of care". It is also implicit in Weiss and Tyink's (2009) definitions of 'coordination' and Frampton's (2012) definition of a 'caring environment'.

A reading of some of the definitions of patient experience prior to 2014, when The Beryl Institute lays a foundation for future work, shows the inclusion of interactions over and above the elements of culture, perception and continuity. Continuity is the second most present element. The cultural element, whether from an organisational perspective or from a personal or societal perspective, is key to the success of the patient experience. However, it is the one that is most underplayed. Perception, on the other hand, tends to be presented as an evaluation or report of the lived experience, linked in some cases to ratings. It should be noted that one of the first elements of contact between professionals and healthcare provider organisations with patient experience was the HCAPS or Picker satisfaction surveys, which are intended to assess patient satisfaction among other elements linked to service delivery.

After this presentation of patient experience approaches, the importance of interactions has become clear in almost all the definitions presented. However, we would like to point out that very few definitions or approaches to the term include "communication" specifically - only two in particular - while the concept of "information" would appear in four other cases. Furthermore, neither concept (neither communication nor information) is part of the definition agreed upon by The Beryl Institute (2014). We understand that the interaction included in the patient experience requires communication whether it is of a personal nature between patients and professionals, between professionals and professionals or of an organisational nature.

Finally, it should be noted that, for the reasons mentioned above, we consider 2014 to be a turning point in the approach to patient experience and, for this reason, in this article we mainly address the elements prior to this date.

2. OBJECTIVE AND RESEARCH QUESTIONS

After reviewing in the previous section the different approaches to patient experience prior to the consensus of The Beryl Institute (2014), it can be seen that interaction is present in most of these approaches. However, the communication and information necessary for interaction appear only occasionally.

Therefore, we propose as an objective of this study to identify the appearance of the concept of communication and its semantic environment in a selection of clinical articles prior to the consensus definition provided by The Beryl Institute (2014). In addition, we added to this search the identification of a possible association of the concept of communication with clinical outcomes of patients.

Due to the coincidence with the dates analysed and because it is a contrasted study, we considered establishing the work of Doyle, Lennox and Bell (2013) as a reference for the sample of articles.

To reach the objective, 4 research questions were developed:

- RQ 1 In how many studies is communication identified as a focus of study in the patient experience?
- RQ 2 In how many studies does terminology associated with communication appear?
- RQ 3 Do patient experience data collection systems require communicative interaction?
- RQ 4 In how many cases are communication variables associated with clinical outcome variables identified?

3. METHODOLOGY

To carry out the research objectives, we conducted a literature review based on a previous selection of 55 key articles on patient experience, identified in the work of Doyle, Lennox and Bell (2013). We considered using the same sample due to the methodological rigour of the selection and its validation, as the study was published in BMJ Open.

The authors constructed a list of terms[3] that covered the semantic field of the patient experience concept and entered them into the EMBASE database, identifying 5323

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[3] Search terms denoting patient experience used by Doyle, Lennox and Bell (2013): Patient-centred care; patient engagement; clinical interaction; patient–clinician; clinician–patient; patient–doctor; doctor–patient; physician– patient; patient–physician; patient–provider; interpersonal treatment; physician discussion; trust in physician; empathy; compassion; respect; responsiveness; patient preferences; shared decision-making; therapeutic alliance; participation in decisions; decision-making; autonomy; caring; kindness; dignity; honesty; participation; right to decide; physical comfort; involvement (of family, carers, friends); emotional support; continuity (of care); smooth transition; emotional support.

articles. From these, they analysed their abstracts, selecting 18 articles. Applying the snowball method, they expanded the sample to 55. The inclusion and exclusion criteria for the list of articles sought to identify original studies or systematic reviews whose focus of study was the measurement of the association between patient experience and safety and effectiveness outcomes, either at the patient or organisational level, using validated tools and whose sample size was greater than 50 subjects (patients). In the case of patient experience measurement, the tools were either generic - Picker or HCAPS survey - or specific - Working Alliance Scale, Multidimensional Health Locus of Control Scale or Usual Provider Continuity index-.

From the sample of 55 articles in Doyle, Lennox and Bell (2013) we discarded the systematic reviews, as they could not establish elements of interaction. We finally located a total of 40 original articles and two individual researchers reviewed them.

The methodology followed for the review of the articles was a content analysis (Krippendorff, 1990) of the original articles. For this purpose, an ad hoc table (Table 4) was drawn up in which we included all the articles, the focus of patient experience raised in them, while identifying the terminology associated with communication linked to the relationships between patients, professionals and organisations. The first columns of the table were based on the classification criteria set out by Doyle, Lennox and Bell (2013) in their original article.

We also included the patient experience evidence collection system for articles focusing on communication, following the parameters used by the authors of the systematic review, the existence of evidence between communication and clinical safety and effectiveness.

4. RESULTS

In how many studies is communication identified as a focus of study in the patient experience? (Q1)

After analysing the 40 articles in the sample we observe that the patient experience focus of the study is analysed in 69 articles. The patient experience focus refers to the elements linked to the patient experience (non-clinical elements linked to the study) on which each paper analysed has focused.

In 17 of the cases, these accounts are related to the communication focus. If we add to these 17 cases all those elements that are directly necessary for their raison d'être, we must add 8 more cases. The aggregated and isolated data are shown in table 1.

Table 1. *Patient experience focus*

Patient experience focus	*Accountings*
Communication, information, interaction, relationship, explanation	25 (17, 2, 3, 2, 1)

Attention, characteristics of care, coordination, continuity, discharge	11 (4, 2, 2, 1, 2)
Satisfaction	5
Trust, faith	5 (3, 2)
Support, alliance	4 (3, 1)
Overall patient experience	3
Adverse events, errors	3 (2, 1)
Involvement in decision-making, patient preferences	3 (2, 1)
Empathy, courtesy, respect and dignity	3 (1, 1, 1)
Quality of services	2
Pain management	1
Family involvement	1
Responsibility	1
Multicultural competence	1
Accessibility	1

Source: *Own elaboration.* The focus of patient experience refers to all those elements linked to the study that are not of a clinical nature. The table presents them in aggregate form, presenting first those with the highest frequencies. The researchers have considered making thematic groupings to facilitate the reading of the results.

In how many studies does the terminology associated with communication appear? (Q2)

Of the 40 original papers analysed, the term "communication" appears in 29 cases, the term "information" in 25, "relationship" in 21 and "interaction" in 21. The mentions according to whether the focus of experience of the paper is communication or not are shown in table 2. Only 3 of the papers do not include either the terms "communication" or "information", and 2 of these do not include any of the search terms. Logically, these three papers do not have communication as the focus of patient experience.

Table 2. *Terminology associated with communication and patient experience focus*

	COM.	NO COM.	TOTAL
Communication	16	13	29
Information	10	15	25
Promotion	1	1	2
Relationship	11	11	22
Interaction	10	11	21
Trust	1	2	3
Empathy	1	1	2

Source: *Own elaboration*

Do patient experience data collection systems require communicative interaction? (Q3)

All evidence on patient experience measurement was collected using tools that require interaction with the patient. This interaction was in 25 cases using surveys, in 10 cases questionnaires, in 6 cases reviewing audio recordings (mostly of visits) and in 2 cases interviews. The data between communication-focused and non-communication focused studies are shown in table 3. Of the 10 surveys used for data collection in the communication-focused studies 5 were not only validated, but were part of the patient experience standards, as was one of the questionnaires.

Table 3. *Patient experience evidence gathering tools*

	COM.	NO COM.	TOTAL
Surveys	10		25
Questionnaires	4	6	10
Interviews	1	1	2
Tapes	3	3	6

Source: *Own elaboration*

In how many cases are communication variables associated with clinical outcome variables identified? (Q4)

Finally, positive associations between communication and clinical outcomes appear consistent across a wide range of disease areas, study designs, settings, population groups and outcome measures. The positive associations found outnumber "no associations" by 56 to 7. No studies were found in which "no associations" outnumbered associations. Table 4 shows the distribution of associations in the last column.

Among the positive associations we can mention the association between empathy competencies and multiculturalism with satisfaction and multiculturalism with adherence, interactions with the clinical team and doctor-patient communication, nurse-patient communication, active listening and showing attention, and among those for which no association was found are communications about medication, empathy competencies with adherence to treatment, communication with depression or communication with the age of the patients.

Table 4. *Analysis of selected studies. Accessible at:* https://figshare.com/articles/dataset/Tabla_4_An_lisis_de_los_estudios_seleccionados/14387519

5. DISCUSSION

The first element of analysis of the different studies was the focus on patient experience, analysing the non-clinical elements of the study linked to experience. Of the four pillars presented by The Beryl Institute (2014), interaction is part of most of the studies, continuity of care appears in very few, while culture and perception are absent in all the papers analysed.

Unlike the approaches to patient experience outlined at the beginning of this article, compiled by Wolf et al. (2014), where the explicit concepts of "communication" and "information" were very much in the minority, the analysis of the bibliographic selection proposed by Doyle, Lennox and Bell (2013), more linked to the clinical field, points to a new role of communication, much more protagonist, and can be considered one of the basic elements that give meaning to this new healthcare speciality.

Specifically, 17 of the 40 originals reviewed in our research included communication in their focus of study linked to the patient experience, to which we could add other elements that directly require communication, such as care, coordination, continuity or discharge, participation in decision-making, family participation, multicultural competence, or accessibility to the system or to the doctor.

This reading of the data linked to the study focuses of each original is refuted when it is observed that in only 2 of the 40 analysed do none of the words linked to communication appear and the number of works with the exact term rises to 29.

It is also noteworthy that the data collection tools for the assessment of the different variables identified in the patient experience from the content analysis require a variety of interactions with patients based on communication with them. Information should be provided on the ways in which patients' experiences with providers have been valuable or problematic, and how healthcare organisations can improve patient care (Agency for Healthcare Research and Quality, 2016). We should also note that while quantitative patient experience information has dominated the measurement and reporting of healthcare quality, qualitative information is becoming increasingly prevalent (Finucane et al., 2018), leading to an increase in interactions directly linked to communicative acts.

We understand that the use of communication is presented as essential in healthcare settings to refer to the patient experience, becoming a cross-cutting concept that cuts across autonomy, choice, confidentiality, dignity, prompt care and quality of basic services (Bleich, Ozaltin and Murray, 2009), while being underpinned by the visualisation of the patient as an active participant, responsiveness of services, individualised approach, lived experience, continuity of care and support (Staniszewska et al., 2014). On the other hand, communication barriers between health care providers and immigrant patients, for example, are extremely common and have significant impact and consequences (Paternotte et al., 2015).

Effective communication is essential to improve health provider engagement and patient experience (Barden A. and Giammarinaro, 2018). In this vein, the 56 positive associations found between communication and clinical outcomes, out of a total of 53, reinforce the rationale for this study and its claim for space in hitherto neglected definitions and approaches to patient experience.

6. CONCLUSIONS

Elements of communication have been identified in most of the studies analysed, not only because of their direct or indirect inclusion in the focus of study in many of them, but also because the term communication and its semantic field are found in almost all of them. On the other hand, it is observed that communication is necessary to use any of the patient experience measurement tools, since these measurements involve interactions with the patient. Finally, we can affirm that most of the interventions in which communication is required have positive associations with clinical outcomes, whether they are linked to patient safety, management of the patient's condition or the clinical outcome of the pathology itself.

7. LIMITATIONS OF THE STUDY

This review is exclusively for clinical studies prior to The Beryl Institute's 2014 consensus definition. Furthermore, for the sake of methodological rigour, the studies included are limited to those found in the reference study by Doyle, Lennox and Bell (2013), an element that poses its limitations while reinforcing the validity of the selection. Moreover, the heterogeneity of the measurements and terminology used in the different original studies makes it difficult to aggregate the results. We should also mention the publication bias, because we, on the one hand, and the authors of the reference study on the other hand, only have access to those studies that have been published, which means that we only have results from studies with statistical significance.

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