

Psychological factors and patient experiences in musculoskeletal specialty care

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Part V

General discussion and Clinical implications / Future Perspectives

Summary

Summary in Dutch/ Nederlandse samenvatting

Appendices



Chapter 10

General discussion and clinical implications / future perspectives

General discussion

In this chapter the main findings and specific methodological aspects of the studies presented in this thesis are discussed. Possible practical implications are described and suggestions for further research are given.

Factors associated with better physical and mental outcome after musculoskeletal trauma

While the evidence favoring the biopsychosocial illness paradigm is increasing, consistent, and convincing, current management strategies continue to adhere more to the biomedical models of illness, in which pathophysiology is mostly addressed by medical and surgical interventions. Whereas unhelpful thoughts and unhelpful feelings are so common during recovery from injury, that surgeons should anticipate and plan for them, since they have notable and consistent associations with the intensity of physical symptoms and magnitude of capability.

The studies in the first part of this thesis focus on psychosocial factors that may be associated with better physical and mental outcome in musculoskeletal care. In chapter 2, a weak correlation was found between the degree of family support and lower perceived magnitude of capability in patients recovering from extremity trauma, which is consistent with previously published evidence that family caregivers play a role in maximizing the health and quality of life for a range of illnesses, for example in older patients with knee osteoarthritis. ¹⁻⁴ Efforts to optimize family involvement in patient care need improvement and standardization, starting by identifying the patient's local support system, documenting them and involving them whenever possible in the rehabilitation trajectory. If family support is absent, the possibility of referral to providers of social services, care management, and home health assistance to create a temporary support system, should also be pointed out to the patient. In multivariable analyses in chapter 3. higher levels of activity intolerance were associated with being retired and with more symptoms of depression, but not with more symptoms of anger. Higher levels of perceived pain were associated with more symptoms of depression and catastrophic thinking. but also not with more symptoms of anger. The absent association between anger and activity intolerance and pain is interesting, as we know there is a relationship between and incapability.⁵⁻¹⁰ The association between symptoms of depression with greater incapability and greater pain intensity is consistent with prior research.^{11–19} This consistent relationship between feelings (e.g. symptoms of depression), thoughts (e.g. catastrophic thinking), pain intensity and incapability corresponds with the biopsychosocial illness paradigm and is not unique to musculoskeletal illness. Thus, the findings of these studies may apply to a wide range of medical conditions.

In the systematic review described in **chapter 4**, there was little or no association between symptoms of depression during recovery and the severity of physical trauma in studies using various measures in various settings. This suggests that clinicians can anticipate symptoms of depression in any patients recovering from physical trauma, not just in those with relatively severe injury.

Surgeons should become more aware of the daily influence of psychological factors on physical outcomes, and their ability to recognize mental health opportunities should be promoted. If we miss the diagnosis of mental health problems and the opportunity to address these, we may do our patients harm. Being mindful of biopsychosocial illness should include having an eye for psychological distress and family involvement, and should involve all trauma patients, given the evidence that both minor and major trauma lead to a notable risk of developing symptoms of depression, which in turn may also lead to worse outcomes.

Evaluation of new questionnaires for measuring patient satisfaction

To help clinicians and health systems to assess and improve patient satisfaction, patientreported experiences measures (PREMs) that address coachable factors, are needed. It is known that provision of high-quality clinical services alone is not sufficient to ensure patient satisfaction.^{24–28} Effective communication and the relationship with the clinician for instance, influence how symptoms are interpreted and dealt with and are also likely to increase satisfaction. ^{29,30} The PREMs that can be used to assess these factors must have enough spread in the values to allow for meaningful analysis and benchmarking. ^{20–23} They are however known to show considerable ceiling effects (high percentage of highest possible scores given). In some studies and in clinical practice, more than half of patients give a top score, which makes it difficult to learn and improve. ^{24,34,45–48} When a ceiling effect occurs, information may be lost at the top of the scale due to the measure's inability to differentiate between very high ratings.

Some patient satisfaction questionnaires have a lower ceiling effect. For example, the Press Ganey Medical Practice Survey has a ceiling effect of 29%³¹ (29% of the ratings are the highest

score) and the Person-Centered Primary Care Measure (PCPCM) for measuring patient experience after a non-specialty care visit has a ceiling effect of 20%.³² However, these questionnaires consist of respectively 24 and 11 items, while long questionnaires are associated with lower response rates.³³ It would be ideal to be able to measure satisfaction, using only a few questions with limited ceiling effects, independent of other factors, without censoring and to have the opportunity to learn from the separate components that determine patient satisfaction.

The Communication Effectiveness Questionnaire (CEQ) (**Chapter 5**), the Guttman-type satisfaction Scale (**Chapter 6**) and the new iterative satisfaction scale (**Chapter 7**) showed a ceiling effect of respectively 46%, 38% and 45%. This is lower than ordinal satisfaction scales, but still higher than the previously mentioned questionnaires (Press Ganey Survey and PCPCM). However, the CEQ consists of only 9 questions and the Gutmann type scales have a maximum of 4 questions. The correlations between the two iterative patient satisfaction scales indicate the potential for changing the satisfaction measures by altering the wording of the questions. We did not analyze the association between these two scales and other PREMs. This is an interesting topic for future research. Theoretically, a 2-item questionnaire may provide enough information for both quality improvement and research endeavors, but we need to find a way to diminish the ceiling effects, especially for the shorter questionnaires.

There seems to be no or just a weak association between the patient satisfaction questionnaires described in chapters 5-7 and PROMs like depressive symptoms and catastrophic thinking, which is consistent with findings of previous studies.^{20,21,24,36,37} PROMs might be considered to measure "How is the patient doing?" while PREMs such as patient satisfaction questionnaires measure "How are the clinicians performing?", and specifically "What can the clinicians do to improve your experience?". One common simplification of satisfaction questionnaires is the so-called net promotor score which is often used for profitably measuring and managing customer loyalty. On a 1-10 scale, customers are asked "How likely is it you would recommend this company to a friend or colleague?". The net promotor score would be an interesting topic for future hospital and out-patient clinic related research.

Information on the patients' experience with provided care at hospital level is not generally available in many countries,⁴⁸ which makes it difficult to compare new questionnaires. Advocates of public reporting believe that making the outcomes available will be helpful to improve the transparency and accountability, and to motivate health care providers to compete on quality by identifying areas of underperformance.^{49,50} On the other hand, publicly available data on patient experience may have potential downsides, including damage to public trust and clinicians' avoidance of high-risk patients.⁵⁰ There is also a risk that clinicians might feel blamed for factors outside their control. In other words, attempts to learn and improve may be at odds with attempts to market and self-promote.

We aim for questionnaires that lead to tailored feedback, coaching and training. First, we need to develop a PREM that measures patient satisfaction in a manner that results in a Gaussian distribution of scores, and then we should attempt to reduce the number of questions to only a few. It would be ideal to measure this construct with one single question, that has no demonstratable ceiling effect and is independent from other factors like PROs, but fulfilling all of these requirements may prove impossible. Perhaps clinicians should be trained to communicate their desire to receive constructive criticism, for reasons of (mutual) improvement of communication and higher patient satisfaction.

Improved patient experience by using new techniques

In **chapter 8**, no significant difference in decision conflict and perceived clinician empathy was observed between patients who received a pre-visit phone call and patients who did not receive a phone call prior to their out-patient clinic visit. A study of pre-visit coordination in patients with diabetes noted improved compliance with recommended tests and screenings after 24 months among patients who had received a phone call, compared to the compliance during the 12 months prior to the pre-visit phone call.³⁸ From this study it seems that it may take some time for pre-visit strategies to influence the decision conflict, treatment compliance, satisfaction and other probable outcomes. The observation of no difference in nonattendance between patients who received a pre-visit phone call and patients who did not receive a phone call in our study is interesting, as the call may work both ways: it might be that some patients are more likely to attend because the call improved the patient-doctor relationship, while others

might be less likely to attend, if the general understanding of their problem is satisfied after the call. Given the observed difference (6% nonattendance with phone call vs 17% without), a larger study might detect a significant difference. Interestingly, when in March 2020 the COVID-19 pandemic broke out, and tele-health was rapidly implemented in health services ^{39–41}, after which a meta-analysis of 29 studies confirmed that patients were equally satisfied with tele-mental health as with an in-person visit, if technology-related issues (e.g. audio lag, bad connection) are minimized.³⁹

In **chapter 9**, we aimed to undestand whether there is an association between the clinician's facial expression of emotions and the patients' psychological distress, unhalthy misconceptions, and experience of their interaction with the clinician. Since this was a pilot study, only 34 patients and six clinicians providing multidisciplinary care at a university health system were included. We found that clinician expressions of happiness, sadness, anger, surpsie, fear, and even disgusare associated with patients' psychological distress (symptoms of anxiety and depression) and degree of faulty thinking (including cognitive biases such as worst-case thinking and fear of painful movement). Despite the small sample size, the correlations between clinician facial expression and patient's mindset were surpsingly strong. A patient's mental health statuscan be measured using self-reported questionnaires, detected in verbal or non-verbal signs, and, as it appears, can be read from the clinician's face. Given that patients not always fill out mental health surveys^{42,43}, measuring the patient's mental health from the clinician's face, signals an alternative approach to accomplish or increase clinician awareness of mental health in their patients.

We demonstrated that clinicians are sensing the patients' mental health. In other words, clinicians are aware (consciously or unconsciously) that patients are experiencing worry or despair. The ability to measurea person's mindset on another person's face using facial recognition technology software offers a powerful coaching opportunity for clinicians. This finding could help to develop training applications that increase awareness among clinicians that communication effectiveness is a skill that benefits from practice as much as technical skills such as physical examination and surgery.

Generalizability considerations

Although the studies presented in this thesis were performed in the setting of musculoskeletal specialty care, the underlying elements of patient experience with provided care probably also apply to many other types of specialty care.⁴⁴ The patients described in chapters 2,3,5-7 were recruited from several musculoskeletal specialty offices, which improves the generalizability of the study outcomes. Since the studies were conducted in Austin, Texas, we predominantly included English-speaking patients, and only in chapter 8 and 9 also Spanish-speaking patients, because not all questionnaires were validated in Spanish or other languages. However, based on prior studies that included Spanish speakers and studies in another major US city, the findings are unlikely to be very different among patients speaking other languages.^{20,45,46} At least in the US, the factors that were measuredseem to apply to patients in all settings. It's however possible that the findings could be different in other countries or cultures, which is an interesting topic for future research.

In chapter 5-7, we included both new and return patients. Return patients may take other aspects of care into consideration when completing the satisfaction questionnaires, for example expectations that have arisen in previous visits. In chapter 5, we did not track if patients were new or return. In chapter 6 and 7, there were no differences in satisfaction between new and return patients. Also, we included both trauma and non-trauma patients in these studies. Given that there were no significant differences in satisfaction between the trauma and non-trauma patients in all three studies, it is likely that the findings apply to the typical mix of patients seen by a musculoskeletal specialist.

Methodological considerations

Most of the studies in this thesis were cross-sectional studies. The patients in the studies answered all questionnaires while they were still in the office, a setting that achieves very high participation rates. One may assume that this had influenced the ratings of satisfaction and experience by patients giving higher scores. However, a study among 150 orthopedic patients found that satisfaction and perceived empathy are relatively stable directly after the visit and 2 weeks later.⁴⁷

Clinical implications / Future Perspectives

There are many ways to implement the findings of this thesis. First of all, surgeons should become more aware of the influence of psychological factors and patient experiences on physical outcomes. Being altruistic is necessary to provide good musculoskeletal specialty care; this also involves learning to recognize, appreciate and prioritize mental health. Training of health care professionals should also concern these aspects of care. We should help patients understand their mood, and coach them towards healthier thoughts and feelings (if needed by referring to a psychologist). The results of the studies in this thesis obviously point to areas for future research.

Noticing

Future research could address incorporating awareness of social and mental health in standard care, making these aspects of care comfortable topics of conversation, and developing interventions to alleviate symptoms and improve physical function by cultivating elevated mood and healthier thoughts. From our studies and the research of others, it is clear there are no typical patients at risk for mental health problems, so we should pay attention to all patients in this respect.

Questionnaires

To further reduce ceiling effects without using more questions in order to improve care, we can refine questions by adding more superlative response categories. Another strategy might be to ensure patients that their honest answers will be used to help clinicians improve specific aspects of care. Finally, it might turn out that verbatim descriptions of how clinicians can improve specific aspects of care might prove more useful than patient-reported satisfaction measures.

Forms of specialty care

An in-person visit could be replaced by a phone call for most patients. A pre-visit phone call has the potential to reduce costs, increase clinician productivity and hopefully also the ability to improve outcomes in musculoskeletal specialty care. Other forms of specialty care may also be suitable, such as self-care websites, text chats, electronic mails, or video telehealth. If necessary or preferred, patients can still be invited for an in-person visit.

Facial recognition technology

Facial recognition technology has the potential to be developed as a tool to help train clinicians in effective communication strategies and to help them become more aware of patients' verbal and nonverbal signs of distress, cognitive bias, and patient experience. Future research should include analysis of facial expressions of emotion technology in bigger populations and more diverse clinical contexts (such as acute settings in trauma surgery).

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