

## **The Dimensions of Patient Empowerment in the Context of Chronic Illness Consultations**

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### ABSTRACT

The purpose of this paper is to determine the underlying dimensions of patient empowerment that are specific to patient-doctor consultations about chronic illness conditions. Patient empowerment is crucial to the chronic illness context, as it entails a high level of patient self-care evident from having to deal with the condition on a daily basis. Since patients need to consult doctors regularly to access prescription drugs and clinical testing to manage the chronic illness conditions, doctors constitute an important source of empowerment to patients. Thus, both, the patient and the health care professional contribute to the patient empowerment process. A synthesis of doctor-communication guidelines for chronic illness conditions and conceptual frameworks of patient empowerment highlighted three domains: *patient control*; *patient participation*, and *physician support*. Qualitative research in the form in-depth interviews with patients and doctors and expert judge ratings was used to generate specific items for each patient empowerment dimensions. The results of a subsequent patient survey containing all the patient empowerment items revealed that patients indeed perceive their empowerment along those three dimensions.

Patient empowerment has been applied to a broad range of patient conditions including: physical disabilities (e.g., Fawcett, White, Balcazar, Suarez-Balcazar, Mathews, Payne-Andrews, Seekins and Smith 1994); disabilities in general (e.g., Hagner and Marrone 1995); mental health (e.g., Chamberlin 1997, Harp 1994), rehabilitation (e.g., Bolton and Brookings 1996); primary care (e.g., McCann and Weinman 1995) and chronic illness (e.g., Feste and Anderson 1995). In comparison to the other health care settings, patient empowerment has been most prominent with respect to chronic illnesses. This is hardly surprising, given the prevalence of chronic illnesses worldwide. Take diabetes for example, “There are currently more than 150 million people with diabetes worldwide. According to WHO this figure is projected to rise to 300 million by 2025, largely due to population growth, ageing, urbanisation, unhealthy eating habits and sedentary lifestyle” (Diabetes Australia Queensland website, no date). These trends are in line with Gerhardt’s (1990) suggestion that chronic disease is becoming more common because drug treatment and surgical intervention have enhanced the life expectancy of people with chronic illnesses.

The nature of chronic illness conditions also help to explain the emphasis placed on patient empowerment in that context. Patients with chronic illnesses need to be as self-sufficient as possible to manage the condition on a daily basis (Anderson 1995, Clark et al 1995, Feste and Anderson 1995, Weaver and Wilson 1994). A continuous physician-patient relationship is highly desirable since the condition requires a health management program that takes the patient’s health history into account (Anderson and Zimmerman 1993). Patients also need to consult their medical physician on a regular basis to obtain prescription drugs and clinical tests (Anderson 1995, Clark, Nothwehr, Gong, Evans, Maiman, Hurwitz, Roloff and Mellins 1995). In turn, patients with chronic illness conditions need to implement treatment regimes engendered from physician-patient consultations (Kaplan, Greenfield and Ware 1989). This is an important point, considering the prevalence of reported patient non-adherence to medical regimens has been primarily attributed to inadequate doctor-patient communication (DiMatteo, Reiter and Gambone 1994; Platt, Tippy and Turk 1994; Donovan and Blake 1992). Thus, patients with chronic illnesses do not only require a close and continuous working relationship with their doctor (i.e., a partnership) they also need to be empowered by their doctor to manage the condition (Anderson and Zimmerman 1993; Clark et al. 1995). The following section illustrates how patient empowerment is manifested in the way patients and doctors communicate.

## **THEORETICAL DEVELOPMENT**

### **The Domains of Patient Empowerment for Chronic Illness Consultations**

Patient empowerment originates from psychological empowerment studies on disadvantaged groups (Feste and Anderson 1995). The empowerment of individuals in

communities has commonly been conceptualised as a process (e.g., Speer and Hughey 1996; Schulz et al 1995; Segal et al 1995; Zimmerman and Rappaport 1988; Kieffer 1984). For example, Zimmerman and Rappaport (1988, p. 726) defined empowerment as a “process by which individuals gain mastery or control over their own lives and democratic participation in the life of their community”. Alternatively stated, the process of empowerment encapsulates the activities, actions and structures that empower individuals (Zimmerman 1995). In the medical context and more specifically in terms of patient-professional healthcare provider interactions, Gibson (1991, p. 359) ascribed a similar definition to patient empowerment by referring to it as: “... a social process of recognizing, promoting, and enhancing people’s abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to control their lives”. Moreover, Winefield (1992) suggested that patient empowerment relates to doctor-patient encounters because medical consultations comprise an interactional helping process that goes beyond being merely a problem solving task. This clearly highlights that patient empowerment can be evidenced from how patients and their doctors interact. A description of the roles performed by patients and doctors in medical consultations about chronic illnesses helps to clarify this point. The doctor is responsible for assessing his/her patient’s health in physical, psychosocial and spiritual terms, and the patient has to review his/her own experiences to determine what works best (Feste and Anderson 1995). This suggests that a doctor requires excellent communication, teaching and consulting skills to motivate the patients to provide information during consultations, and to dedicate their time and effort to medical regimens that have been developed with the help of the doctor.

A complete definition of empowerment must also incorporate outcomes. Empowerment outcomes are reflected through individuals’ *autonomy in decision making*, *self-reliance*, *participatory democracy*, and *experiential social learning* (Perkins and Zimmerman 1995). Thus, individual empowerment embodies, but is not limited to, a feeling of control as it also includes individuals’ learning and active participation (Schulz et al.1995). Outcome based definitions have also been proposed for patient empowerment. For example, Dunst and Trivette (1996, p.334) defined patient empowerment outcomes as “...both the behaviors that are strengthened and learned as a result of participatory experiences, and the control appraisals people make about their own capabilities and those pertaining to control over important life events and situations”. Another paper identified the following empowering patient outcomes resulting from patients’ interactions with health care professionals: *self-efficacy*, *sense of control*, *sense of mastery*, *growth*, *a sense of connectedness*, and *improved health and well being* (Gibson 1991).

Conceptual frameworks of patient empowerment further highlight the outcome and process components. For example, in the context of patient participation in self-help organizations, Connelly et al. (1993) proposed a hierarchical model of patient empowerment that consists of four dimensions. Firstly, *participation* occurs when a client gets involved with the organisation. Secondly, *choosing* refers to a client experiencing freedom as well as accepting responsibility for his/her choices (self-control, courage,

options, freedom). Thirdly, *supporting* transpires when a client is accepting of and helps fellow clients (caring, relating, coaching, accepting, sharing). Fourthly, *negotiation* transpires when a client becomes assertive and cooperates with fellow clients (equality, respecting, cooperating and taking a position). Clearly, the hierarchical model primarily views patient empowerment as a process (participation → choosing → supporting → negotiation), nevertheless, terms such as *self-control* and *courage* also represent empowerment outcomes. Dunst and Trivette (1996) defined patient empowerment as an (i) *empowerment ideology* (i.e., building on strengths rather than correcting weaknesses), (ii) *participatory experiences* (i.e, collaborative transactions) and (iii) *empowerment outcomes* (i.e., learned and strengthened behaviors and control appraisals). Again, both process and outcome attributes have been used to conceptualize patient empowerment. In contrast to the previous two patient empowerment frameworks, Gibson's (1991) three dimensional patient empowerment model is specific to patient encounters with health care professionals. The first dimension covers a range of outcome based empowerment attributes that relate specifically to the *client* including: self-determination, self-efficacy, sense of control, motivation, self-development, learning, growth, sense of mastery, sense of connectedness, improved quality of life, better health and sense of social justice. The second patient empowerment dimension focuses on the process features of *client-nurse interactions*: trust, empathy, participatory decision-making, mutual goal setting, co-operation, collaboration, negotiation, overcoming organisational barriers, organising, lobbying, legitimacy. The third dimension covers empowerment attributes specific to the *nursing practitioner* (e.g., the nursing practitioner is a good educator) and includes: helper, support, counselor, educator, resource consultant, resource mobiliser, facilitator, enabler, advocate. Gibson's (1991) third dimension clearly suggests that health care professional behaviours are a core component of a patients' empowerment. Translating these dimensions to the doctor-patient context, patient empowerment can be defined in terms of:

- (i) a patient's control over the illness management (*patient attributes*);
- (ii) a patient's level of participation during medical consultations (*interaction attributes*);
- (iii) a patient's support/education received from the doctor (*doctor attributes*)

To generate specific items which operationalise these three patient empowerment dimensions, the next section firstly reviews literature on consultation guidelines for doctors treating patients with chronic illness conditions. Secondly, it summarizes the findings of in-depth interviews with patients and doctors which were conducted to explore how doctors empower patients with chronic illness conditions.

### **Operational Definition of Patient Empowerment Dimensions**

The three patient empowerment dimensions stated in the preceding section were used as a guideline to generate items for a multi-item measure of patient empowerment specific to the doctor-patient dyad. The themes of *patient participation*, *patient control*, and *patient support from the doctor* are readily apparent from the proposed practice approaches for doctors who treat patients with chronic illness conditions. To illustrate, TABLE 1 categorizes the practice guidelines into the three dimensions of patient empowerment:

**TABLE 1**

**Categorization of Guidelines for Treating Patients with Chronic Illness Conditions:**

<p>Guidelines relating to <i>patient control</i> is reflected by highlighting the need:</p> <ul style="list-style-type: none"><li>○ to reinforce a patient's confidence in his/her ability to manage treatment regimens and the daily ups and downs of the disease. (Daltroy 1993)</li><li>○ for the patient to :<ul style="list-style-type: none"><li>- have an idea of what he wants in life;</li><li>- regard poor blood glucose levels as a challenge to be dealt with-not as proof of inability;</li><li>- to distance him/herself from the diabetes;</li></ul></li><li>○ when having solved a problem in theory the patient immediately acts to correct mistakes,</li><li>○ the patient is not afraid of hypoglycaemia and believes that long-term complications can be retarded or halted by his own actions; and</li><li>○ the patient actively seeks new diabetes knowledge and discusses his diabetes with others knowing that they generally know less about diabetes and diabetes care than he does himself.</li></ul>
<p><i>Patient participation</i> in medical consultations is covered by highlighting the need for patients to:</p> <ul style="list-style-type: none"><li>○ communicate their perspectives and preferences; making decisions; ask the doctor to explain information (Golin, DiMatteo and Gelberg 1996);</li><li>○ raise underlying concerns about the condition; engage in interactive conversation and reaching short-term objectives related to the control of the disease that are important to patients (Clark et al. 1995);</li><li>○ air psycho-social issues and question doctors (Stott, Rollnick, Rees and Pill 1995);</li><li>○ raise concerns; share models of disease, symptoms and treatment, and agree on treatment goals and priorities, and jointly identify and plan to overcome compliance difficulties (Daltroy 1993);</li><li>○ clarify their expectation of treatment, and involve themselves and family in the development of a treatment plan (Worth 1993)</li><li>○ share expectations with doctors regarding the clinical encounter, cause, severity, symptoms of illness and susceptibility to complications, goals/costs/risks/benefits of treatment (Feinberg 1988); identify barriers and strengths relating to achieving self-care; establish a plan with the assistance of the provider (Funnell et al. 1991).</li></ul>
<p>Guidelines relating to <i>physician support/education</i>:</p> <ul style="list-style-type: none"><li>○ giving the patient all the information desired (critical issues, alternatives, risks/benefits, uncertainty) and covering the probabilities of outcomes (Golin et al. 1996);</li><li>○ enabling the patient to gain access to dietary specialists, addressing all aspects of diabetes management and lifestyle issues (Hampson et al. 1996);</li><li>○ equipping the patient with the criteria to judge the success of the treatment plan and to know what to expect over time, providing guidelines for handling potential problems and explore contingencies in managing the disease (Clark et al. 1995);</li><li>○ explaining the meaning of diagnosis in a way that is clearly understood, to provide information about all the options when recommending medication or surgery, informing of reasons for recommending medication to surgery and all the possible side effects of each (Grace 1995);</li><li>○ making all factors for consideration and/or choice explicit (Stott et al. 1995);</li><li>○ providing written information on the disease and treatment regime, to explain the purpose, dosage, common side-effects (Daltroy 1993);</li><li>○ explaining what is happening to the patient physiologically and what the options are to improve his/her health (Denz-Penhey and Campbell-Murdoch 1993);</li><li>○ providing patients with diaries to record antecedents of asthma exacerbations, symptoms, actions taken, outcomes, and peak expiratory flow rates; providing written instructions about use of medication especially for treatment of severe attack; and explaining how each medication works to prevent symptoms (Worth 1993);</li><li>○ educating the patient regarding diet and arthritis, what arthritis is, surgery and alternative treatments for arthritis (e.g., acupuncture, bee sting, holistic medicine), occupational therapy (devices to help at home), physical therapy (use of heat, cold, exercise, joint protection), medication and how to communicate with the doctor (Buckley et al. 1990); and</li><li>○ engaging pedagogical approaches which enhance patient compliance such as pacing the amount of</li></ul>

information to avoid overload, using simple understandable language without medical jargon, devising mechanisms for helping patients to remember advice and reinforcing essential points of view by review, discussion or summary (Feinberg 1988).

Finally, the third empowerment dimension, *patient control*, is also addressed by the studies summarised in Table 3.3.: For example, Reichard (1996) covers several ways diabetes patients experience control:

- the patient has an idea of what he wants in life;
- the patient regards poor blood glucose levels as a challenge to be dealt with-not as proof of inability;
- the patient is able to distance himself from the diabetes;
- when having solved a problem in theory the patient immediately acts to correct mistakes,
- the patient is not afraid of hypoglycaemia and believes that long-term complications can be retarded or halted by his own actions; and
- the patient actively seeks new diabetes knowledge and discusses his diabetes with others knowing that they generally know less about diabetes and diabetes care than he does himself.

Golin et al. (1996) address patient control in terms of the patient's desire for control, self-efficacy, assertiveness, self-care, and adherence. According to Daltroy (1993) a patient's perceived control can be enhanced if the physician reinforces the patient's confidence in his/her ability to manage treatment regimens and the daily ups and downs of the disease. Similarly, Feinberg (1988) highlights the need for physicians to encourage self-management, develop a repertoire of motivational techniques such as justification, emphasis and the use of authority or referent power (Feinberg 1988).

In conclusion, Table 3.3 highlights that physicians need to communicate with patients in a way that encourages patients to participate, learn and develop a feeling of control to manage their chronic illness. The research hypotheses tested in this study propose that patient empowerment in the form of patient participation in medical consultations with the doctor, patient control over the chronic illness condition, and patient perceived support from the doctor results in greater patient satisfaction with the service provided by the physician, enhances patient trust in and commitment to the doctor, and leads to favourable future behavioural intentions such as recommending doctor to others or complying to the doctor's medical regimens. The following three sections in this chapter use the findings of previous doctor-patient communication studies to derive and support the research hypotheses that guide this study. As none of the studies address all three dimensions simultaneously, the sections primarily review doctor-patient communication studies that have examined the impact of at least one of those empowerment dimensions on patient outcomes.

## RESEARCH METHODOLOGY

### Research Context

While patients differ in their desire to actively participate in and take on responsibility for medical-decision making (Mort 1996), some health care problems call for a significant input from patients to manage their health. This is particularly the case for chronic illness conditions such as diabetes or asthma, as patients need to actively manage and monitor the problem over an extended period of time. They also need to consult their medical physician on a regular basis to obtain prescription drugs and clinical tests, and therefore require a close and continuous working relationship with a physician (Anderson 1995, Clark, et al 1995). The benefit of patient empowerment programs are apparent from research cited by Vernarec (1999), which found patients who received special training regarding their chronic illness condition experienced more relief, better communication with their doctors, less fatigue and greater role function. Considering that medical consultations are a platform for physicians to empower patients and strengthen the professional relationship with clients, patient interactions with physicians who are consulted on a regular basis about the chronic illness are an appropriate research context for this study. Moreover, patient empowerment is not likely to result from a single medical encounter but rather develop over a series of medical consultations. Therefore, patients' global evaluation of their experiences with their regular physician is the appropriate level of analysis for this study.

### Development of Initial Set of Patient Empowerment Items

Primary qualitative research was conducted in order to develop a multi-item measure of patient empowerment in the context of patient consultations with the regular physician about their chronic illnesses. The qualitative research entailed semi-structured in-depth interviews with ten patients (with chronic illness conditions including asthma, diabetes, chronic fatigue syndrome and breast cancer), four doctors (general medical practitioners from different medical clinics) and two expert judge ratings (marketing academics). The interviews were taped and transcribed and then thoroughly examined to familiarise the researcher with the qualitative data and to identify core themes. To enhance the rigor of the qualitative data analysis and to derive sample items for the multiple dimensions of patient empowerment, the interviews were subsequently analysed using QSR Nud.ist 4 (Qualitative Solutions and Research 1995). A two-stage expert judging procedure was then used to review the items generated from the qualitative data analysis and enhance content validity of the resulting measure of patient empowerment. The first group of judges categorized each item into one of the three dimensions. A subsequent group of judges then indicated how representative each item was of the specified patient empowerment dimension.

This resulted in the patient empowerment items listed in Table 2:

<b>Table 2</b>
<b>Items for the Patient Empowerment Constructs</b>
<i>Patient Control Items</i>
1. Patient feels responsible for the management of the illness.
2. The patient has significantly changed his/her lifestyle and habits to improve his/her health (e.g., diet control).
3. The patient monitors his/her own progress.
4. The patient focuses on the best way to manage the illness rather than on the problems.
5. The patient ensures that medication is always at hand.
6. The patient checks for warning signs (e.g., worsening eye-sight, chest pain).
7. The patient knows what triggers symptoms (e.g., eating sweets, exposure to cats)
<i>Patient Participation Items</i>
1. The patient brings monitoring results (worksheets) to the consultation.
2. The patient chooses his/her treatment.
3. The patient directs the doctor on what needs to be addressed.
4. The patient discusses information received from other sources (e.g., family, friends, media) with the doctor.
5. The patient asks questions during the consultations.
6. The patient requests from the doctor to see his/her medical record.
7. The patient fully informs the doctor about his/her concerns.
8. The patient discusses alternative/non-mainstream care with the doctor.
<i>Patient Support Items</i>
1. The doctor checks the patient's skills to administer medicine and monitor progress.
2. The doctor uses diagrams/models and other tools to explain things to the patient.
3. The doctor checks the patient's understanding of what is going on.
4. The doctor informs the patient about new things coming up.
5. The doctor makes medical information more meaningful for the patient.
6. The doctor promotes the patient's health and illness prevention.
7. The doctor points out potential complications of the illness to the patient.
8. The doctor informs the patient about all the possible treatment outcomes (e.g., side effects).
9. The doctor provides the patient with a booklet on how to control the illness.
10. The doctor endorses illness related community programs and support groups.
11. The doctor encourages the patient to engage in self-care.
12. The doctor provides clear instructions on what to do in different situations.
13. The doctor points out educational seminars and relevant health care services.
14. The doctor provides the patient with written material about the illness.

Exploratory Investigation of Dimensionality

As specified in the research context section, patient empowerment was examined in the context of patients' global experiences with their regular physician. A total of 693 adult patients (17% overall response rate) belonging to four different chronic illness associations in the State of Western Australia (Diabetes; Arthritis Foundation; Heart Support Group and Chronic Fatigue Syndrome Support Centre) completed a mail survey. The questionnaire contained all of the 29 patient empowerment items outlined in Table 2. The questionnaire was pre-tested on a convenience sample of ten adult patients with various chronic illness conditions (insulin dependent diabetes; non-insulin dependent diabetes; asthma). The low response rate of 17% is reflective of the lengths of the questionnaire and the mail-based approach that questions patients independently of a visit to the doctor (Wensing et al 1994).

The respondents were divided into two groups based on how they rated their general health. This was done to assess the generalisability of the global patient empowerment dimensions from patients who perceive their health to be excellent compared to patients who rated their general health as less than excellent. The nature of chronic illnesses requires patients to be empowered so they can better manage their chronic illness on a daily basis, regardless of their general health. Therefore, the empowerment dimensions should be equally relevant to both groups. The scale used by the respondents to indicate their perceived general health ranged from "1" very poor health to "7" very superior health. As the mean ("5.1") and the median ("5") values for health perceptions were quite high patients (423 respondents) who indicated "1" to "5" on the perceived general health scale were categorised into the *satisfactory health* group. The remaining patients (256 respondents) who circled "6" to "7" on the perceived general health scale were classified as the *excellent health* group (patients who did not respond to that question were excluded from the subsequent data analysis). Table 5.2 provides a chronic illness breakdown of the two sample groups that were used to test the research hypotheses of this study.

As addressed in the preceding section, primary qualitative research had to be conducted to generate items for the multi-dimensional patient empowerment construct that is specific to the dyadic context of patient-physician consultations about chronic illnesses. Table 2 listed all the items representing each of the patient empowerment domains: (i) *patient control over the chronic illness condition*; (ii) *patient participation during medical consultations* and (iii) *patient support from the physician*. All the items were presented in a Likert scale format ranging from 1 to 7 and with *strongly agree/strongly disagree* anchors.

## PATIENT SURVEY DATA ANALYSIS AND RESULTS

The purpose of the data analysis was to ascertain whether the three dimensions of patient empowerment (abbreviated as *patient control*, *patient participation* and *physician support*) are supported by quantitative data. Accordingly, factor analysis (principal component analysis restricted to three factors with oblimin rotation and Kaiser normalisation) was undertaken on the patient empowerment items using the *satisfactory*

health sample data. Table 3 presents a summary of the factor analysis results. The total variance extracted by the three factors was 51%.

The subsequent Cronbach alpha analysis and plotting item-total correlation analysis on each construct (i.e., patient empowerment dimension) led to the elimination of the following items:

**1. Patient Control**

- (i) Patient Makes Lifestyle Change
- (ii) Patient Keeps Medication Handy

The deletion of these two patient control items, resulted in a  $\alpha = 0.82$ .

**2. Patient Participation**

- (i) Patient Keeps a Medical Record

The deletion of this patient participation item resulted in a  $\alpha = 0.79$ .

**3. Physician Support**

- (i) Doctor Encourages Patient Responsibility.

The deletion of this physician support item resulted in a  $\alpha = 0.94$ .

	Factor 1 <i>Physician Support</i>	Factor 2 <i>Patient Control</i>	Factor 3 <i>Patient Participatio n</i>
Doctor Keeps Up to Date	0.86		
Doctor Informs About Complications	0.82		-0.21
Doctor Enhances Understanding	0.81		
Doctor Engages in Health Promotion	0.79		
Doctor Provides Clear Instructions	0.78		
Doctor Provides Written Plans	0.77		
Doctor Covers Treatment Outcomes	0.77		
Doctor Gives Ample Time	0.70		
Doctor Suggests Seminars/HC Services	0.69		
Patient is Aware of the Medical Record	0.67		
Doctor Uses Written Materials	0.66		
Doctor Uses Tools	0.65		
Doctor Makes Info Meaningful	0.65		
Doctor Monitors Patient's Skills	0.65		
Doctor Checks Medicine Administering Skills	0.61		
Patient Monitors His/Her Own Progress		0.74	
Patient Feels Responsible for Illness		0.74	

	Factor 1 <i>Physician Support</i>	Factor 2 <i>Patient Control</i>	Factor 3 <i>Patient Participation</i>
Patient Manages the Illness		0.70	
Patient Knows Symptoms		0.67	
Patient Checks for Warning Signs		0.65	
Patient Controls Daily Symptoms	0.28	0.64	-0.20
Patient Makes Lifestyle Change		0.49	0.30
Doctor Encourages Patient Responsibility	0.43	0.44	
Patient Keeps Record		0.40	0.25
Patients Keeps Medication Handy		0.32	0.23
Patient Discusses Alternative Care			0.72
Patient Discusses Other Info Sources			0.71
Patient Asks Lots of Questions	0.20		0.59
Patient Directs the Doctor		0.21	0.56
Patient Provides Treatment Input	0.31		0.47
Patient Fully Informs the Doctor	0.33	0.22	0.34
<b>Eigenvalue</b>	10.91	3.02	1.98

Note: Loadings of less than 0.2 are not shown to improve clarity of the table.

Using the same extraction and rotation method, all the remaining patient empowerment items were again tested in a factor analysis (restricted to three factors). One of the *patient participation* items “Patient Fully Informs the Doctor” loaded on all three factors and was hence deleted. The final Cronbach alpha for the *patient participation* item (i.e., after the deletion of the cross loading item) was  $\alpha = 0.77$ . The reliabilities of the remaining items for the three patient empowerment dimensions were strongly supported by a subsequent Cronbach alpha analyses and item-total correlation plots involving a second dataset (i.e., the *excellent health* patient sample). No sharp item-total correlation drops were evident and all the Cronbach alphas (*physician support*  $\alpha = 0.93$ ; *patient control*  $\alpha = 0.80$ ; *patient participation*  $\alpha = 0.72$ ) were of an acceptable standard based on the 0.70 threshold suggested by Nunnally (1978).

## DISCUSSION AND IMPLICATIONS OF RESULTS

In the context of chronic illnesses, the results reported in the preceding section, provide strong support for the three dimensions of patient empowerment: (i) *patient control*; (ii) *patient participation* and (iii) *physician support*. Prior to this study, marketers considered patient empowerment from a mass communication perspective. For example, McClain et al (1994) highlighted the opportunity for marketers to empower health care consumers through health promotion, education and disease prevention programs. Similarly, Roth (1994) identified social marketing programs as a means to empower and motivate patients to become more involved in their health care. This study shifts the focus of

patient empowerment from mass communication to physician-patient consultations. Whilst Soafer (1994) extended the role of marketers to assist physicians in the provision of more targeted information to their patients, they do not specifically address how doctor and patient interactions empower patients. Moreover, this study has demonstrated that providing patients with adequate information during medical consultations only presents one form and one dimension of patient empowerment, namely *physician support*. Two other dimensions, *patient participation* during medical encounters and *patient control* over the chronic illness condition are also important patient empowerment components.

The doctor-patient relationship focus of this study highlights the relevance of the patient empowerment concept to the relationship marketing area. A client empowerment focus encompasses a two-way relationship. To illustrate, patients become empowered by actively participating during medical consultations. However, this form of empowerment requires a supportive physician who fosters patient learning and mutual decision making. Whilst empirical research in relationship marketing has investigated collaborative communication with respect to distribution channels (e.g., Mohr et al. 1996; Anderson and Narus 1990), the patient empowerment measure developed in this study presents a communication assessment tool specific to customer and service provider interactions. It covers communication behaviours of both parties by examining the extent of a *client's participation during consultations*, as well as the *perceived support from the service provider*. In addition to these communication process factors, the patient empowerment measure incorporates a unique communication outcome dimension labeled *patient control over the chronic illness* (e.g., the patient knows what triggers the symptoms). Alternatively stated, it reflects how client-service provider consultations enhance a client's ability to manage the problem he/she consulted the service provider for. The coupling of communication process and outcome elements results in a richer description of relationships between clients and service providers.

Physicians could use the patient empowerment constructs as a performance measure by administering a simple and short survey to patients with chronic illness conditions. Unlike other measures of performance, this instrument addresses both the performance of the physician (perceived support from the physician) as well as the performance of patients (patient participation during medical consultations and patient control over the chronic illness). Accordingly, it highlights areas for improvement for both parties (i.e. the patient and the doctor).

#### LIMITATIONS OF THE STUDY AND FUTURE RESEARCH SUGGESTIONS

Even though this study surveyed a range of patients with different chronic illness conditions and analysed the data by dividing the sample into two distinctive patient groups (satisfactory health; excellent health), generalizations to other patients must be made with caution. The patients surveyed were members of their representative chronic illness support group. This is an important consideration, as it has been suggested that merely joining a support group (such as a client run drop in centre for people with a chronic mental illness) signals the initial level of patient empowerment (Connelly et al.

1993). Hence, findings may not be representative of all patients with chronic illness conditions. Therefore, this study should be replicated with patients who are not members of a support group and/or have other chronic illness conditions (e.g., asthma; high blood pressure). Following that, the study could be extended to a broader health care setting such as preventative health care. McCann and Weinman (1996) highlighted the importance of general medical practitioners

The cross-sectional survey design of this study was appropriate to develop a patient empowerment scale and establish a positive relationship between the patient empowerment constructs and the patient outcome variables. Considering the dynamic nature of the patient empowerment construct (Gibson 1991), the patient empowerment scale could be used in a longitudinal study to investigate how changes in patients' circumstances and experiences impact on patient empowerment over time. From a doctor-patient relationship perspective, it would be particularly beneficial to test the true value of continuity in care to patient empowerment.

Due to pragmatic reasons, only patients were surveyed in this study. Ideally, responses should have been sought from both parties, patients and doctors, given the patient empowerment dimensions relate to doctor-patient interactions. In addition, there are several other sources of patient empowerment that should be considered along side physicians' support in future studies. A patient's family and social environment is also seen to be a significant contributor to patient empowerment (Dunst and Trivette 1996). This highlights the possibility that patients may become empowered by consulting and interacting with a range of individuals, experts and organisations. Therefore, a future study could determine the level and type of contribution different health care professionals, support groups and social networks make to patients' perception of empowerment, especially in terms of patient education and support. Undoubtedly, patients may also learn more about their chronic illness condition from non-personal sources such as the media, health care books and magazines, and internet sites.

Ouschan et al. (2000) extended the relevance of patient empowerment in doctor-patient consultations to other professional service providers such as accountants and financial advisors, as they also require substantial client input and both parties stand to benefit from a continuous service provider-client relationship. Thus, it would be insightful to examine the generalisability of the patient empowerment dimensions to other professional services contexts.

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