



Arthritis Community Research &  
**Evaluation Unit (ACREU)**

**Client-Centred Rehabilitation II:  
Healthcare Professionals'  
Perspectives**

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## ***EXECUTIVE SUMMARY***

This report summarizes the findings of the second phase of the program of research on Client-Centred Rehabilitation conducted by the Arthritis Community Research and Evaluation Unit in partnership with the Rehabilitation Program Policy Unit of the Mental Health and Rehabilitation Reform Branch, Ministry of Health and Long Term Care.

### Objectives of Overall Program of Research

- To further develop the concept of client-centred care as it applies to rehabilitation described in the Ministry of Health and Long Term Care Draft Policy and Service Delivery Framework for Rehabilitation (Provincial Rehabilitation Reference Group, 2000)
- To identify client-centred parameters for rehabilitation programs
- To identify criteria for evaluating the extent to which various rehabilitation programs are client-centred

The first phase of the research consisted of a literature review and focus groups with adult clients with chronic physical disability who had received a course of rehabilitation in the publicly funded system in Ontario. The results of the first phase of the research are contained in the companion document: Client-Centred Rehabilitation (Cott et al., 2001). The second phase of the research, reported in this working paper, consisted of a literature review and focus groups with rehabilitation health care professionals from various disciplines and institutions to examine their

perspectives on client-centred rehabilitation in the publicly-funded rehabilitation system in Ontario.

Most of the literature related to client-centredness presented the perspectives of various healthcare professionals, most frequently physicians and occupational therapists. The focus of the literature from the healthcare professionals' perspectives was on client-healthcare professional relationships, communication within those relationships and barriers to a client-centred approach.

The traditional hierarchical system of healthcare, with a biomedical philosophical perspective, demonstrated a competing philosophy to approaching rehabilitation from a client-centred perspective. Five key dimensions are integral to client-centredness: a biopsychosocial perspective, the 'patient-as-person', sharing power and responsibility, the therapeutic alliance and the 'doctor-as-person'.

Browder and Vance (1985, p. 1033) suggest that the responsibilities of healthcare professionals should be directed by the complexity of the illness and not from the self-declared duties of healthcare professionals. With that in mind, as well as the information gained from the literature review, the next step in this project was to more fully understand the important components of client-centred rehabilitation from the perspective of healthcare professionals. To this end, we conducted focus groups with a variety of healthcare professionals who work with clients requiring rehabilitation.

Four main themes emerged from the focus groups and interviews with healthcare professionals.

They were:

- 1) the value of clients' participation in the rehabilitation process;
- 2) challenges and struggles experienced by the client and/or family;
- 3) challenges and struggles experienced by the healthcare professional; and
- 4) restraints imposed by the healthcare system.

Healthcare professionals spoke of these themes from three different perspectives. These perspectives included impressions or perceptions of what healthcare professionals think clients *want*; healthcare professionals' professional opinions of what clients *need*; and what the healthcare system *will allow*.

The following components are important to client-centred rehabilitation from the health care professionals' perspectives:

- Family involvement
- Client as "equal"
- Goal ownership
- Client as team member
- Philosophical shift in healthcare professionals approach to care
- Information sharing
- Emotional support provision
- Decision-making
- Access to rehabilitation through more than one door
- Follow-up as a continuum of access
- Environmental and organizational considerations

## **CHAPTER 1: BACKGROUND**

### ***1.1 Arthritis Community Research and Evaluation Unit***

The Arthritis Community Research and Evaluation Unit (ACREU) was funded in July 1991 under the Ontario Ministry of Health's Health System-Linked Research Unit Grant Program. ACREU was established to carry out health services research with the goal of reducing the impact of arthritis on individuals, their families, and on the population.

### ***1.2 Partnership with the Rehabilitation Program Policy Unit***

This research project was conducted by ACREU in partnership with the Rehabilitation Program Policy Unit of the Mental Health and Rehabilitation Reform Branch, Ministry of Health and Long-Term Care. As a Health Systems-Linked Research Unit, ACREU worked with Ministry staff to finalize the research question and to contribute to the client-centred rehabilitation policy framework. Research results will be incorporated into broader initiatives aimed at reforming Ontario's rehabilitation system.

### ***1.3 Objectives***

The objectives of the overall research program are:

- 1) To further develop the concept of client-centred care as it applies to Rehabilitation described in the Ministry of Health and Long-Term Care Draft Policy and Service Delivery Framework for Rehabilitation (Provincial Rehabilitation Reference Group, 2000). Further development of

the concept of client-centred care as it applies to Rehabilitation includes building upon what was learned about the perspectives of clients (Cott et al., 2001) by seeking input from healthcare professionals;

- 2) To identify client-centred parameters for rehabilitation programs; and
- 3) To identify criteria for evaluating the extent to which various rehabilitation programs are client-centred.

The specific objective of this phase of the research is to:

- 1) examine the perspectives of rehabilitation healthcare professionals as to the important components of client-centred rehabilitation.

### ***1.4 Methodology***

The methodology consisted of :

- review of the literature
- focus groups with healthcare professionals from various disciplines and institutions who were involved in the care of clients who required adult inpatient rehabilitation.

## CHAPTER 2: LITERATURE REVIEW

### 2.1 Literature Search Strategy

Relevant literature was identified from searches of computerized databases using both the British and American spellings of the term patient-centred(ness). Searches were restricted to English language journals published within the last 30 years. Criteria for inclusion in the database were papers that provided a review, theoretical/conceptual frameworks or models, research or commentary relating to client-centredness.

Data bases and web sites used to obtain information on client-centredness included:

Pubmed

[<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed>] which includes:

Premedline

Medline

HealthSTAR

CINAHL

Wilson Business Abstracts

EMBASE

Social Work Abstracts

Picker Institute ([www.picker.org](http://www.picker.org))

Kennedy Institute for Bioethics

<http://www.georgetown.edu/research/nrcbl/>

To attempt to focus the search on rehabilitation, key words used in the search strategy in combination with rehabilitation were as follows: best practice, evidence-based practice, case-mix, client-centredness, patient-centredness, person-oriented, patient-focused, client-focused, patient participation, client participation, patient decision-making, client decision-

making, Planetree model and quality of care.

### 2.2 Overview

In the literature there are a variety of terms that address issues related to client-centredness. These include client-centred practice, client-driven care, patient-centred care, patient-focused care, among others (Gage, 1994; Kreitner, Hartz, & Pflum, 1994; Sumsion, 1999; Wilkins & Evans, 1997). All of these terms have the client as the focus. However there are variations as to the processes involved with each approach to client-centredness. For the purposes of this research project we will refer to the concept as it applies to rehabilitation and will call it client-centred rehabilitation. The terms client-centredness and client-centred rehabilitation will be used interchangeably.

A client-centred approach is identified in the paper “Managing the Seams: Making the Rehabilitation System Work for People” (Provincial Rehabilitation Reference Group, 2000) as one that facilitates responsive, individually appropriate, functionally-based goal-setting involving the active and informed participation of the client. Several other similar definitions of client-centredness exist in the literature (McWhinney, 1989; Townsend et al., 1997). Likewise, various authors propose components of a client-centred approach.

Based on our review of the literature and the focus groups with clients (Cott et al, 2001), we identified the following important components of a client-centred approach in rehabilitation:



- 1) Client participation in decision-making and goal-setting;
- 2) Client-centred education including appropriateness of information tailored to client's needs and wants;
- 3) Evaluation of outcomes from client's perspective, not just impairment level outcomes, but also at level of activity and participation;
- 4) System response to client feedback;
- 5) System coordination, for example interdisciplinary teamwork;
- 6) Continuity of care including discharge planning and linkage to the next phase of rehabilitation;
- 7) Follow-up;
- 8) Family involvement;
- 9) Effective communication;
- 10) Respect;
- 11) Choice;
- 12) Access;
- 13) Emotional support;
- 14) Physical comfort; and
- 15) System-wide support for client-centred care.

### ***2.3 Client-Healthcare Professional Relationships***

The role of the person with disabilities in the rehabilitation process has evolved considerably in the last few decades. In the 1940's and 50's the client/practitioner relationship in rehabilitation was based on the traditional Parsonian model that was doctor-centred and grounded in paternalism (Parsons, 1951). The doctor decided what was in the patient's best interests, and the patient was expected to comply. In the 1960's and 70's, the evolution of health care teams

meant that the doctor/patient dyad expanded to include other professional care professionals. However, the professionals continued to define and determine what was in the patient's best interests. A rise in consumerism in the 1970's and 80's led to the consumerist model in which the person with the chronic illness takes the more active role in decision-making with the practitioner being more passive and following direction from the consumer (Haug and Lavin, 1981; Albrecht, 1992; Fougeyrollas, 1995). In response to the rise in consumerism and research that indicates that preserving clients' autonomy and control results in improved health outcomes, rehabilitation professionals have become interested in a middle ground "client-centred" approach based on mutuality in which clients and practitioners are equal partners in decision-making (Morgan, 2000).

We chose to use the term client-healthcare professional relationships for two reasons. The first reason was that use of this term can then be generalized to various disciplines and the second reason was based on a suggestion from Epstein (1997) where he suggests putting the client first places emphasis on the centrality of the client. Since much of the literature on client-centredness with the medical and occupational therapy professions focused on communication aspects of encounters between clients and healthcare professionals, this section of the literature review will provide an overview of client-healthcare professional relationships.

In contrast to the dearth of literature as to the clients' perspectives on client-centred rehabilitation, the majority of the literature is written from the healthcare

professionals' perspectives. Much of the literature that addressed the perspectives of healthcare professionals was related to client-healthcare professional relationships and communication within those relationships. As with the term client-centredness, we discovered a variety of terms for client-healthcare professional relationships. These included patient-physician partnerships, patient-physician relationships, healthcare professional-patient relationships, physician-patient interactions and professional-patient relationships, among others (Epstein, 1997; Charles, Gafni & Whelan, 1999; Emanuel & Emanuel, 1992; Gage, 1994; Kaplan, 1989; Purtilo, 1995). Much of this literature was profession-specific and was focused on either occupational therapy or the medical profession. However, the findings and the views expressed in this literature can be extrapolated to apply to other rehabilitation disciplines.

### **2.3.1 Models of Client-Healthcare Professional Relationships**

There were different models described in the literature of client-healthcare professional relationships. Four models were outlined by Emanuel and Emanuel (1992). They are the paternalistic model, the informative model, the interpretive model and the deliberative model. All of these models recognize the role of patient autonomy in the client-healthcare professional relationship. However, they are distinguished from each other by the way they view patient autonomy and to lesser and greater degrees accommodate the notion of client-centredness.

The aim of the paternalistic model is to ensure that clients receive interventions that best promote their health and well-

being. Clients are provided with selected information by their healthcare professional. This selected information will encourage the client to consent to the intervention that the healthcare professional considers best. The healthcare professional can determine what is in the best interests of the client. Participation by the client is minimal. The concept of client autonomy is client assent to what the healthcare professional determines is best.

The informative model is occasionally also referred to as the scientific, engineering or consumer model. The objective of the client-healthcare professional interaction is for the healthcare professional to provide the client with all relevant information. The healthcare professional provides all the facts and the client makes decisions based on his or her values. Client autonomy is evident by client control over decision-making.

With the interpretive model the healthcare professional informs him or herself of the client's values and then assists the client to select the intervention that realizes those values. It is important to note that the healthcare professional does not dictate to the client. Rather, the healthcare professional acts as a counselor or advisor. This model involves the client and healthcare professional working together to come to decisions. Autonomy of the client involves the client understanding his or her values.

The deliberative model is intended to assist clients to determine and choose the best health-related values. In contrast to the interpretive model the focus is on health-related values only. The healthcare professional fulfills the role of teacher or friend. A dialogue occurs

where the healthcare professional offers advice on what the client should do. Client autonomy is evident by the fact that the client is empowered to make his or her own decisions.

An enlightened care model is also described (Soever, 2002). With an enlightened care model, the healthcare professional provides clients with all relevant information; encourages clients to express their values, both health-related and otherwise; assists clients, in a benevolent manner, to make decisions based on these values; and considers what is in the best interests of clients.

Additional models of the client-healthcare professional relationship are described in the literature (Charles et al., 1999; Epstein, 1997; May, 1975). The activity/passivity model assumes that the client cannot participate in the care and that the healthcare professional knows best. This model does not recognize the importance of client autonomy and as a result does not contribute to the notion of client-centredness. Like the interpretive model, the contractual/covenantal model allows for open discussion of values. A patient-centred model is described where the illness must be understood from the perspective of the client. A diagnostic perspective is provided to the client, by the healthcare professional and there is a sharing of power between the roles of client and healthcare professional. A family systems model takes into consideration individual as well as family values, while an ethnographic model takes into consideration the impact of cultural values on illness.

Of all of these models, the interpretive, deliberative and enlightened care models seem to align themselves most with the concept of client-centredness. These

models allow for all of the 15 components of client-centred rehabilitation that were previously identified in the literature, to be addressed in a manner where the client is the focus.

#### ***2.4 The Role of the Healthcare Professional in Shared Decision-making***

One of the main focuses of client-healthcare professional relationships is the component of decision-making. Closely related to client-centred rehabilitation is the concept of shared decision-making. Kasper Mulley and Wennberg (1992) highlight the importance of shared decision-making to determine what the client *wants*.

The meaning and morality of any clinical actions largely depend on the quality of the decision-making, the interpersonal relationship and the shared meaning of the two (Quill and Cassell, 1995). “Shared meaning of the two” refers to “the quality of the decision-making with respect to the client-healthcare professional relationship.” Facilitation of the decision-making process is the healthcare professional’s role according to Ellenchild Pinch and Parsons (1997).

Several authors advocate a shared decision-making model to promote a client-centred approach (Charles et al., 1999; Coulter, Entwistle, & Gilbert, 1999; Deber, 1994; Kasper, Mulley, & Wennberg, 1992). A study using focus groups with breast cancer clients, addressed clients’ views on client participation in decision-making (Sainio, Eriksson, & Lauri, 2001). Two main questions were asked of the participants. The questions were as follows:

- 1) What are their perceptions of patient participation in decision-making?
- 2) Which factors promote and which factors hinder patient participation in decision-making?

Participants identified the following ways of participating in decision-making from the client's perspective: asking questions; receiving information; and choosing between given alternatives. Participants also suggested that nurses and physicians should participate in decision-making by asking questions, giving information, and presenting alternatives. Participants also put forth factors related to nurses and physicians that promoted client participation in decision-making and factors related to nurses and physicians that hindered client participation in decision-making. Factors that promoted client participation in decision-making included treating clients as equals, making sufficient time available and encouraging clients to participate. Factors that hindered client participation in decision-making included treating clients as objects, adherence to routines, problems with disseminating information and lack of time.

Coulter, Entwistle and Gilbert (1999) pointed out the importance of quality information in the shared decision-making process. They proposed that clients require sufficient and appropriate information, including detailed explanations about their condition and the likely outcomes with and without treatment, if clients are to make informed choices. Focus groups were conducted with clients with various health conditions to discuss their information needs and their opinions about specific materials. In the focus groups, clients reported overall

dissatisfaction with their experiences of communication with health professionals. They identified a lack of information about their condition and treatment options. With respect to information materials, participants initially suggested that any information was better than none. However, on closer examination the content of the information was also identified to be important to clients. Based on this study, the authors developed a list outlining why clients need sufficient and appropriate information. The list was as follows:

- Understand what is wrong
- Gain a realistic idea of prognosis
- Make the most of consultations
- Understand the processes and likely outcomes of possible tests and treatments
- Assist in self care
- Learn about available services and sources of help
- Provide reassurance and help to cope
- Help others understand
- Legitimize seeking help and their concerns
- Learn how to prevent further illness
- Identify further information and self help groups
- Identify the "best" healthcare professionals.

Deber (1994) distinguishes between two elements of choice in a shared decision-making model. These two elements are problem-solving and decision-making. Problem solving refers to "tasks in which there is a correct answer, expertise is often necessary, and preferences are often irrelevant" (Deber, 1996). Decision-making tasks "require prior problem-solving, but they also

consider the value that patients place on the outcomes.” The problem-solving task is closely linked to the importance of quality information noted previously. Deber (1994) further suggests that the success of a shared decision-making process is critically dependent on the way in which information is presented. She noted that client decisions can be influenced by what, when and how relevant information is given and that large amounts of new information can be overwhelming and cause confusion.

In recognition that clients are ‘ready’ for information at different stages, Charles Gafni and Whelan (1999) proposed a shared decision-making model with four necessary characteristics. This model was based on physician-patient encounters. They claimed that the decision-making approaches lie between the three predominant client-healthcare professional models of paternalistic, shared and informed. The four necessary characteristics of the authors shared decision-making model are as follows:

- 1) At a minimum, both the physician and patient are involved in the treatment decision-making process;
- 2) Both the physician and patient share information with each other;
- 3) Both the physician and the patient take steps to participate in the decision-making process by expressing treatment preferences; and
- 4) A treatment decision is made and both the physician and patient agree on the treatment to implement.

These characteristics reflect the dynamic nature of a shared decision-making process.

### ***2.5 The Relationship Between Evidence-based Practice and Client-centredness***

With the increasing necessity for healthcare professionals to use evidence-based practice in their approach to healthcare, there is also some literature that addresses the relationship between outcome and a client-centred approach. Coulter, Entwistle and Gilbert (1999) suggest that there are grounds for optimism that involving clients in a shared decision-making process produces clinical outcomes that are more positive than would have occurred if the same clients were not as actively involved in their care.

A study involving 39 family physicians and 315 of their patients demonstrated that patient-centred communication influenced patients’ health through perceptions that their visits were patient-centred (Stewart et al., 2000). The study was an observational cohort that was designed to assess the association between patient-centred communication in primary care visits and subsequent health and medical care utilizers. Patient-centred communication was scored based on office visits that were audiotaped. As well, patients were asked for their perceptions of the patient-centredness of the visit. The outcomes were patients’ health, assessed by a visual analogue scale; self-report of health, using the Medical Outcomes Study Short Form-36; and medical care utilization variables of diagnostic tests, referrals and visits to the family physician. The two measures of patient-centredness were correlated with the outcomes of the visits. Positive

perceptions of finding common ground were associated with better recovery from their discomfort and concern, better emotional health and fewer diagnostic tests and referrals.

In another study the effects of physician-patient interactions on the outcomes of chronic disease were assessed (Kaplan, Greenfield, & Ware, 1989). The data were from three separately conducted randomized controlled trials and a fourth nonequivalent controlled trial.

Diagnostic groups included patients with ulcer disease, hypertension, diabetes and breast cancer, respectively. The findings of this study showed that more patient control; more affect, especially negative affect expressed by physicians and patients; and more information provided by physicians during office visits were associated with better health status reported at follow up. Health status was measured by functional status and subjective evaluations of health.

A recent study in the rehabilitation field examined the effect of using a client-centred instrument, the Canadian Occupational Performance Measure (COPM) on patients' perceptions of active participation in the rehabilitation process (Wressle, Eeg-Olofsson, Marcusson, & Henriksson, 2002). The premise of the authors was that, when asked, most clinicians would say they practise in a client-centred manner. Utilization of a tool such as the COPM demonstrates evidence of this claim. The authors also utilized two functional assessment tools, the Clinical Outcome Variables (COVS) and the Klein-Bell Activities of Daily Living (ADL) Scale to assess function. There were two groups of clients, including a control group and an experimental group. Both groups were assessed with the two functional measures and a structured

interview within 2-4 weeks after discharge. In addition, the experimental group utilized the COPM. Diagnostic categories included geriatric, stroke and home rehabilitation. Results of this study showed that more clients in the experimental group perceived that their treatment goals were identified, were able to recall the goals, felt they were active participants and perceived themselves better able to manage after completed rehabilitation. Scores of functional ability as measured by the (COVS) demonstrated that in the control group, the median score for change was lower than in the experimental group. However, the change for the control group was still statistically significant. When paired data were analyzed for both the COVS and the Klein-Bell ADL Scale there were statistically significant improvements for both the control and experimental groups.

Despite not demonstrating differences in physical outcome with a client-centred approach, this study did demonstrate beneficial effects on clients.

## ***2.6 Barriers to Client-centredness at the Healthcare Professional-Level***

We also found a significant volume of literature that addressed barriers to a client-centred approach. Barriers at the healthcare professional-level were reviewed, as they related to individual or personal aspects of the healthcare professional. Lesser detail in the literature, was paid to barriers relating to the client-level and system-level.

Barriers, from the occupational therapy literature, categorized according to their source were as follows:

- i) client-level;
- ii) healthcare professional-level;
- and

iii) system-level (Law, Baptiste, & Mills, 1995; Wilkins, Pollock, Rochon, & Law, 2001).

Sumsion and Smyth (2000) conducted a study in the United Kingdom using a postal questionnaire asking 60 occupational therapists to rate 16 barriers to client-centred practice that had been identified from the literature. These barriers were rated with respect to how much each barrier prevented client-centred practice. Some of these barriers were on a personal level while others related more to circumstances or the system. The three highest ranked barriers were of a more personal nature and were as follows:

1. The therapist and client have different goals;
2. The therapist's values and beliefs prevent them from accepting the client's goals; and
3. The therapist is uncomfortable letting the client choose their own goals.

Lesser-ranked barriers such as 'The therapist is short of time' or 'The therapist and client are of different cultures' were related to circumstances and/or the system. In this same study methods of resolution of barriers were also addressed. Barrier resolution focused mainly on educational strategies with occupational therapists.

Most barriers to client-centred practice in the nursing literature are system-based. However, barriers to client-centredness at the level of the professional, were suggested by Millers and Koop (1984).

In the medical literature, barriers to practising in a client-centred manner focus on communication and power

balance issues. The challenge of communication was discussed (Brown, Weston, & Stewart, 1995; Brown, Weston, & Stewart, 1989; Harrison, 1982). Common problems of communication included misdiagnosis and patients and physicians disagreeing as to what is the patient's main problem (Brown et al., 1995; Brown et al., 1989).

Another barrier to client-centredness is the hierarchy of the medical system. Harrison (1982) discussed how medical and non-medical members of a community clinic in Vancouver have an equal say in decision-making and review each other's work. Further, he reported how some doctors may find such a system threatening. The task of physicians and patients sharing expertise and power is another barrier to client-centredness. An additional barrier reported is the paradoxical relationship between patient empowerment and physician control. For example, Skelton's (1997) study of patients with lower back pain found that patients willingly left themselves in the control of the physician in order to meet their goals for health prevention. A contradictory situation was demonstrated by Deber, Kraetschmer and Irvine (1996) that showed that patients were not willing to hand over total control to their physicians with respect to decision-making. However, nor did these same patients want to fully participate in problem-solving.

## ***2.7 Underlying Philosophical Perspective of Healthcare Professionals***

Historically, the healthcare system has tended to be a hierarchical system, placing the physician in a dominant role and the patient in a relatively passive role (Bloom, 1995; Gage, 1994). Inherent in this historical perspective is a

competing philosophy with client-centredness. One of the specific barriers to practising rehabilitation in a client-centred manner is the underlying philosophical perspective of medical and other healthcare professional training. Coles (1995) reminds us that especially in the initial phases of healthcare professional education, the education is uni-professional. The content is usually scientific and has a biophysical emphasis. Patients' illnesses are reduced to a set of signs and symptoms (Mead & Bower, 2000). Coles (1995) also suggests that healthcare professionals often see their role as identifying and solving the patient's problem. This represents a biomedical model.

In contrast, Mead and Bower (2000) describe five conceptual dimensions that are integral to client-centredness in the client-physician relationship. They are:

- 1) A biopsychosocial perspective;
- 2) The 'patient-as-person';
- 3) Sharing power and responsibility;
- 4) The therapeutic alliance; and
- 5) The 'doctor-as-person'.

A biopsychosocial perspective challenges a key assumption of the biomedical model, that illness and disease are coterminous. A combined biological, psychological and social perspective is thought to provide a more inclusive understanding of clinical presentation (Brody, 1987; Mead & Bower, 2000). The 'patient-as-person' dimension implies that the personal meaning of illness must be understood. From a client-centredness perspective, the client is seen as an experiencing individual rather than the object of some disease entity (Mead & Bower, 2000). The third dimension, sharing power and

responsibility, is quite self-explanatory and relates to previous discussions about shared decision-making. The therapeutic alliance is determined by the relationship between the doctor and the patient and more specifically by the doctor's role in achieving the desired emotional context. Various therapeutic attitudes such as empathetic, caring, and sympathetic are put forward as factors that enhance the therapeutic alliance. The 'doctor-as-person' dimension concerns the personal qualities of the doctor and the effect on the client-healthcare professional relationship. This dimension allows for a subjective component on the part of the doctor in the relationship.

## ***2.8 Summary of the Literature Review***

In the literature, a variety of terms were utilized to address issues related to client-centredness. A lot of the literature related to client-centredness presented the perspectives of various healthcare professionals, most frequently physicians and occupational therapists. Generally speaking, these perspectives can be extrapolated to apply to other rehabilitation healthcare disciplines. The focus of the literature from the healthcare professionals' perspectives was on client-healthcare professional relationships and communication within those relationships.

Several models of client-healthcare professional relationships were identified. Those models most compatible with a client-centred approach included the interpretive model, the deliberative model and the enlightened care model.

The importance of shared decision-making for a client-centred approach was reviewed. Shared decision-making



was further divided into two elements of choice, problem-solving and decision-making. Problem-solving was determined to be closely related to information-sharing. Content, quality and timeliness of information-sharing was shown to be critical to a client-centred approach.

Evidence in the medical literature demonstrated a positive correlation between client-centredness and medical outcomes. Literature from the occupational therapy profession demonstrated that use of an outcome measure that was client-centred facilitated clients to feel more participatory in their rehabilitation and better able to manage after they had completed their course of rehabilitation.

Many barriers to a client-centred approach were identified in the literature. The occupational therapy literature summarized the barriers as being related to the client, the therapist and/or to the organization. Barriers related to the therapist were often of an individual nature.

The traditional hierarchical system of healthcare with a biomedical philosophical perspective demonstrated a competing philosophy to approaching rehabilitation from a client-centred perspective. Five key dimensions that are integral to client-centredness were described. They included a biopsychosocial perspective, the 'patient-as-person', sharing power and responsibility, the therapeutic alliance and the 'doctor-as-person'.

Browder and Vance (1985, p. 1033) suggest that the responsibilities of healthcare professionals should be directed by the complexity of the illness and not from the self-declared duties of

healthcare professionals. With that in mind, as well as the information gained from the literature review, the next step in this project was to more fully understand the important components of client-centred rehabilitation from the perspective of healthcare professionals. To this end, we conducted focus groups with a variety of healthcare professionals who work with clients requiring rehabilitation.

## **CHAPTER 3: FOCUS GROUPS**

### ***3.1 Focus Group Methodology***

We used a focus group methodology to examine client-centred care from the perspective of healthcare professionals in the publicly-funded rehabilitation system. In designing focus groups, two different principles of sampling and recruitment can be used: break characteristics, in which one samples to differentiate groups from each other; and control characteristics, in which one looks to discuss common aspects across groups (Knodel 1993). We chose to sample using control characteristics. The group participants all had something in common, they were involved in rehabilitation of adult clients with chronic physical disability, but they were heterogeneous with respect to professional background and the specific types of clients with which they worked.

Each focus group consisted of healthcare professionals of various disciplines and from various institutions. One planned focus group ended up being an in-depth interview because only one participant attended the session. There was a second in-depth interview because that participant was unable to travel. Healthcare professionals included physicians, physiotherapists, social workers, occupational therapists, professional practice leaders, nurses and hospital administrators.

#### **3.1.1 Inclusive Criteria**

Participants had to be healthcare professionals who worked in a setting where adult clients receive rehabilitation for chronic physically disabling conditions. They had to be able to

participate in a focus group session in English lasting one to two hours.

#### **3.1.2 Sampling for Focus Groups**

Six separate focus groups and two in-depth interviews were held with healthcare professionals who worked in a setting where adult clients with chronic disabling conditions received rehabilitation.

Potential participants were identified through hospitals in the Greater Toronto Area. Some of these hospitals were stand-alone rehabilitation facilities and others had rehabilitation services within an acute care hospital. They were contacted over the telephone by staff at ACREU using a standardized script that described the research. Potential participants were then asked if they were interested in participating in the study. Individuals who expressed interest were then provided with an official letter of invitation and an information sheet outlining further details about the study. Dates were then arranged for focus group participation. Efforts were undertaken by staff at ACREU to recruit participants who did not work with or know each other, for each focus group. This was not always possible. This was done to make participants feel more comfortable to voice their opinions openly.

#### **3.1.3 Setting**

Focus groups and one in-depth interview with healthcare professionals were held at central locations that were convenient for participants. One of the in-depth interviews was conducted at the participant's home because she was unable to travel. Written consent was obtained from all participants prior to each focus group or in-depth interview.

### **3.1.4 Procedure**

The focus groups and in-depth interviews were conducted following guidelines set out by Krueger (1994). Prior to the focus group or interview, participants received a letter of confirmation and an information sheet. At the beginning of the focus group or interview, the focus group leader emphasized the confidential nature of the discussion. Consent forms were signed by participants prior to the focus groups.

The focus groups were conducted by the principal investigator and two doctoral students with backgrounds in physical therapy and client-centred rehabilitation. The students were trained and supervised by the principal investigator (PI). One of the doctoral students kept a speaker log and took notes. Each participant was assigned a number and a running log was kept of the first phrase of each speaker. The purpose of the speaker log is to aid with the analysis. Specifically, the speaker log clarifies if a particular view has been expressed by a number of persons rather than by one person many times. For confidentiality purposes, only the first names of participants were used in the focus group and interview discussions.

Questions were open-ended and nondirective initially to encourage participants to identify issues of importance to them. As the discussion progressed, the questions became more specific to issues of client-centredness and probes were used to stimulate further discussion if necessary (refer to 3.1.5). Some questions were based on themes that arose when the client groups were studied.

Focus groups and interviews were audio-taped and transcribed. To ensure confidentiality, when tapes were transcribed names were omitted and participants were referred to by their initials. The data were entered into NUD\*IST Version 6 (N6), a program designed to assist with management of qualitative data.

Data were analyzed using a constant comparative approach (Strauss and Corbin, 1990). A coding scheme was developed using an iterative, inductive approach. Two research associates independently did initial open-coding of the focus groups. In consultation with the principal investigator, they then compared and contrasted codes to develop a finalized coding scheme. Once a satisfactory level of agreement was reached, two research associates coded each focus group and interview, using this coding scheme. They subsequently met to review the coding to ensure consistency in the definitions and interpretations of codes. Once coded, the data were entered into N6, a qualitative data software package. The data were then examined for common themes within and among each focus group and interview.

### **3.1.5 Healthcare Professional Focus Groups Interview Guide**

Focus group and interview discussions were opened with the following brief introduction. Examples of the focus group and interview questions are listed.

#### ***Introduction***

Thank you for agreeing to participate in this focus group or interview. As you know, we are trying to gain a better understanding of healthcare professionals' perspectives regarding

client-centred care in rehabilitation.  
There are no right or wrong answers.  
We are interested in your experiences  
and opinions. Let me reconfirm that the  
discussions that we will have today are  
confidential and should not be repeated  
outside the group.

### ***Focus Group Questions***

1. To begin, could you tell me about  
your background in rehabilitation?  
Where do you work?  
Who do you work with?  
How did you come to work in rehab?
2. Could you tell me about a typical  
client/patient in your rehab program?
3. Could you walk me through the  
rehab process in your program, what  
happens typically to clients?  
Process that worked well, not so  
well?  
What makes process easier/harder?
4. How are decisions made?  
Treatment/care plan/goal setting/give  
examples  
Prallee: Are clients involved in  
decision-making?
5. Do you feel the rehabilitation  
services are organized around the  
needs of the clients rather than the  
professionals? Ask for examples.
6. Clients have told us that they did not  
feel their rehab programs prepared  
them with the skills they needed to  
live in the community. Clients  
expressed the feeling that they were  
“dropped like a brick” when  
discharged to the community. Please  
comment.
7. Clients also indicated that their  
emotional needs were not being met.  
Please comment.
8. Is there anything we have not talked  
about that you think should be  
mentioned? Are there things that  
make it easier for you to involve  
clients in their rehab?

## CHAPTER 4: RESULTS

Four main themes emerged from the focus groups and interviews with healthcare professionals. They were:

- 1) the value of clients' participation in the rehabilitation process;
- 2) challenges and struggles experienced by the client and/or family;
- 3) challenges and struggles experienced by the healthcare professional; and
- 4) restraints imposed by the healthcare system.

Healthcare professionals recognized and valued clients' participation in their rehabilitation. However, they talked about struggles and challenges to practising in a client-centred manner from three main perspectives – those of the client and/or family, the healthcare professionals themselves and the system. These perspectives included impressions or perceptions of what healthcare professionals think clients *want*; healthcare professionals' professional opinions of what clients *need*; and what the healthcare system *will allow*.

### ***4.1 The Value of Clients' Participation in the Rehabilitation Process***

Participants described the challenges they faced in encouraging clients to participate in their rehabilitation.

“...there is a real attempt to make things client-centred and what is it that you want to accomplish because if we don't, a lot of patients will sit back and say 'do to me, make me better' where it's really them, I try to get them to understand that it's *you* that

makes yourself better. I just coach you.”

Participation in rehabilitation by clients includes responsibility on their part in the form of physical, emotional and cognitive participation.

“... the patient knows their own body best...they know in terms of what is important to them, in terms of what you know what their beliefs are, what their values are, what gives their life quality as compared to what we think maybe gives them quality. So, we have to educate them in a sense of what our expertise is but they have to equally educate us in terms of what their needs are and what their values are and what we'll, what we can do to in fact make sure that they can continue living with those same values and beliefs and the two things have to mesh.”

#### **4.1.1 Family and the Client**

Family was identified as being an important consideration for healthcare professionals when rehabilitating clients in a client-centred manner. When family members, including friends and neighbours, are actively involved in the rehabilitation process, healthcare professionals identified the importance of addressing their needs and concerns, as well as the needs and concerns of the client. There was even some suggestion that by supporting families in a positive way this would contribute to improved outcomes of clients.

“... our assessment is really geared towards identifying what it is that's meaningful for the client to work on but also what

the family will want to work on. So for us the client-family-centred notion goes hand in hand. We don't see it as just client-centred or just family-centred because we really value the family's perspective."

"We will provide all the supports to him and to his family there and bend like every rule we can to make sure that, that the decision he makes is a well-supported decision and it is a really hard decision. ...I think it's a really, it's a good example of being very client-centred and looking at the entire family unit as the client here."

"I think the thing that I got a real bias towards is ensuring that there is support to support the families; strengthen from the families because if they are the primary support system for the individual... I find that many services tend to be more centred on the individual as opposed to the family so if there could be more resources put in place to strengthen the families and support their ability to cope then I think it would help the clients in turn."

A close relationship between 'client-centred' and 'family-centred' was identified. These quotes illustrated that consideration of family included recognizing their participation in the rehabilitation process as well as recognizing and providing support for their needs. Healthcare professionals also identified a role that families often play in advocating for healthcare resources for family members.

"...there are a few people on my floor and their process has been expedited to whether it is a palliative care facility, even, or a rehab facility, is because the families have called themselves and advocated for the family member. I'd say 'where is my family member on your wait list? Do you know that my mom is waiting for rehab? Can you please look into the application?' And then within a week the bed comes up."

#### **4.1.2 Healthcare Professional-Client Relationships**

Healthcare professionals identified the importance of establishing open, communicative relationships with their clients. Developing such a rapport was thought to enable practice that is client-centred. Healthcare professionals also suggested that continuity of service professionals is important to clients.

"So when we do have the time, I think teams do an excellent job and I think individual team members take that time to establish a rapport with patients. ... It is harder to get that rapport going with the client where they can openly tell you what their wishes are and their goals but I think if the time is there and the team works well together then it, it happens."

"What people like is to hear that staff are interested in what they want to do while they are there or what they want to be able to do when they leave, not what the professional thinks they should be able to do. ...So, that's quite a switch for the profession[al]s. ...

it seems that in that program, staff have made the leap. In the other programs they haven't yet though. It is still provider-driven."

"I think what they feel good is the continuity of the staff. ...they feel that they're somebody who knew what they were like, who has an understanding of the family, the work problem, the physical problem... You know that I think that healthcare is a very human side, it's a personal touch."

The terms "equality" and "authority" were used by healthcare professionals to describe what they thought was the client's role in the client-healthcare professional relationship. By clients possessing this role, their participation in the rehabilitation process can be maximized.

"When I talk about the inter-professional care delivery model I talk about the client or the patient being an equal, an equal partner in the team."

"It's more an equality thing and I need to know as much about you as a patient for me to bring in my expertise as an OT. Otherwise, if I am dictating to you, you are not going to get the best care. And, I think that's coming through more."

"I think there is a reason why everybody wants to do what they want to do and having, not so much for the younger population, but I find that they're, they, they somewhat have an understanding why they probably shouldn't do

it but they are still going to do it and if they're happy why not?"

### 4.1.3 Goal-setting

With respect to goal-setting, healthcare professionals referred to goals from three different perspectives. These perspectives were from the client, the healthcare team and the institution. Healthcare professionals did acknowledge the importance of the perspective of the client in the goal-setting process.

"I don't know if part of it's experience in terms of working for so long but I think I am better able to say my goals aren't important for this person, it's what their goals are."

"One, a young lady who was in ICU who had lupus who came up and she had lots of goals that we wanted to work and so one of the things she liked to do was to... go bowling. So, we took her..."

The identified perspectives of the healthcare team and the institution with respect to the goal-setting process will be discussed later in this chapter.

### 4.1.4 Team

The concepts of multidisciplinary and interdisciplinary teams surfaced repeatedly in the focus groups with healthcare professionals. Teams were of two types – those that were comprised solely of healthcare professionals and those that included the client *and* healthcare professionals. A shift to inclusion of the client on a more regular basis was identified. Often, the level of participation by the client on the team was influenced by the acuity of the

client's condition, their readiness to be part of the team, their level of understanding, and their physical, emotional and cognitive ability to participate. Potential benefits of inclusion of the client as a team member were suggested.

“When I talk about the inter-professional care delivery model, I talk about the client or the patient being an equal, an equal partner in the team... the clients are the people who know, who are the experts in what life is like for them... so I guess for me the thing would be treat the patient as a member of the team.”

“And I think too, that each team member contributes so much to, I guess, the team as a whole because each one comes in with their own expertise but we don't only learn from each other, we learn a lot from the client or the patient, which is very rewarding.”

Teams comprised solely of healthcare professionals were also described. When teams were described in this manner, the value of the participation of the client in the rehabilitation process appeared to go unrecognized.

“When they come to the ambulatory care setting, the interdisciplinary team including nursing, social work, OT, PT, perhaps massage, whoever is needed – did I miss anybody?”

“When you say ‘we’ are you talking about physio’ specifically?” “Physio’ specifically, but it’s kind of hard to really to work in isolation. I

mean, I work very closely with the rest of the team.” “Okay, PT, OT, social work, the care leader, who is a nurse, dietitian.”

## ***4.2 Challenges and/or Struggles Experienced by the Client and/or Family***

Healthcare professionals talked about struggles and challenges to practising in a client-centred manner from three main perspectives – those of the client and/or family, the healthcare professionals themselves and the healthcare system. This next section will include the areas where healthcare professionals described what they felt clients and/or families *wanted* or *needed*, but often had difficulty attaining.

### **4.2.1 Readiness of Clients to Participate in Rehabilitation**

Healthcare professionals realized that the responsibility that comes with clients' readiness to participate in rehabilitation, is dependent on factors such as the acuity of the condition or illness; the client's level of cognition; emotional status; physical ability to participate; and level of understanding of the illness, rehabilitation process and options available.

“Often they are not ready. ...they are not ready to really discuss long term plans. ...They often, as soon as they arrive there they see what their goals could possibly be because when they are actually in acute care, they really can't even conceptualize what if they would ever have a functional life again because they automatically think they've just lost everything that could possibly help them. So, it is very



difficult especially at that time to explain to them that you actually have a lot more options than you think you do or perceive to have so that's usually education is a huge aspect and once I think they become educated, then they are quite ready to set their own goals."

Healthcare professionals felt that reaching a state of 'readiness' to participate in rehabilitation was often a challenge for clients and/or their families. The opportunity to receive client-centred rehabilitation depends in part, on the degree of participation in rehabilitation by clients and/or their families. Healthcare professionals described degree of 'readiness' to participate in rehabilitation as a predictor of the degree of client-centredness in the process.

#### **4.2.2 Client-Healthcare Professional Relationships**

With respect to the client-healthcare professional relationship, healthcare professionals recognized that clients were not always seen as equals in the healthcare environment. This power imbalance was thought to be secondary to a lack of knowledge by clients regarding their condition as well as 'old-school' thinking on the part of healthcare professionals.

"I would say from my end the client has less of a voice at the table just by virtue of not having knowledge of what is going [on] with their body. So, education is a huge part of just to give them enough information so they can then say 'so I can do this' or 'I can't do that, I understand that now.'"

"We, in my experience we have providers who are, lots of providers who are provider-driven, some healthcare professionals who are patient-centred. So, a lot of us who are educated to be at you know, as the experts, and so we are going to be the ones in charge."

"Part of what we haven't learned to do is negotiate and maybe that is another thing that will help people become more client-centred, healthcare providers become more client-centred and that is, is to negotiate around outcomes, not just 'you have to do it my way' but when we've been the ones in the position of power all the time, I mean people in powerful positions don't have to negotiate so we never learn. ...It's not been part of our learning to be what we, what we've become."

This style of thinking and practice based on that thinking were in contrast to the more "savvy" approach of clients.

"I think that consumers are more savvy. They come in and they have knowledge and then they have internet access, you know. They've done their research and everything they read tells them you know, 'you're powered. You have the right to ask questions. You know more about yourself than we do' and that's the truth... and so they come in... and they have expectations ...and they want excellence in care ...and they deserve that ...and they're the navigators of their own health, which is the

way we want it to be. It's just that we perhaps are in transition. They've already arrived and we are still in transition."

#### **4.2.3 Information-sharing**

Healthcare professionals recognized the need for clients to both give and receive information. Deficits in the information-sharing process were identified. These deficits related to the timing as well as the content of the information that was either being given or received. Finding the appropriate time to give information to the attending healthcare professionals posed challenges for clients and/or their families, as did not receiving appropriate information in a timely fashion.

"... when people are ready to talk about this feeling in there and what we would like staff to be able to do then is respond when people make that overture. ...So, it's sometimes, it's a burden to have only one person know this if there are lots of things that other people can do..."

"I do see a lot of elective surgical patients and I think it would be easier to have a client-centred approach if they had an idea [ahead of time] of what was going to happen to them postoperatively. Often....they have no idea of what they are getting themselves into. Some of them don't know that they are going to be wearing a brace for three months, things like that so you know, so instead of spending all the time educating them about what's just happened to them and what they are going to be dealing with from restrictions

perspective... they have time to think about it."

"No and you can tell them the same thing everyday for a number of days and every time you tell it, it's like they've never heard that before and really they haven't because they haven't been ready to."

Clients giving information to healthcare professionals was considered important for healthcare professionals to develop their treatments in a client-centred manner.

#### **4.2.4 Importance of Hope**

Healthcare professionals identified the importance of hope in the rehabilitation process, for their clients. Hope was identified by healthcare professionals as being important for clients who have chronic illnesses such as spinal cord injury, acquired brain injury, amputation, cerebral vascular accident and cancer. Healthcare professionals suggested that hope plays a role in various aspects of goal attainment including motivation and actual goal achievement. While acknowledgement of hope by the healthcare professionals was identified as being important in the healthcare process, balancing hope with realistic expectations and goals was also identified as an important function for healthcare professionals.

"You can't deny somebody the hope and as they are working through this thing themselves, they get, they develop other avenues of hope. So, we don't ever say, at least we tell people not ever to say, 'well, that is unrealistic'... because we don't

understand the power of hope that people have.”

“Sometimes you have to balance realistic expectations with this hope, because if you take away the hope they have nothing; they will stop trying.”

“You know I think it’s an issue of hope. ... They have to be able to look to the future and be able to grab something that can pull them through between now and then and if that means that once I get there, things will be better, then that’s what they have to hang onto because I mean if they don’t have hope, what do they have?”

### ***4.3 Challenges and Struggles Experienced by the Healthcare Professional***

Healthcare professionals also identified struggles and challenges within themselves as individuals and as professionals, which posed problems for practising in a client-centred manner.

#### **4.3.1 Respect for Autonomy**

There was an overall desire expressed by healthcare professionals to respect the wishes and autonomy of their clients and families and to promote their participation. However, this was counterbalanced by many challenges. Healthcare professionals acknowledged that respecting the autonomy of their clients was most easily achieved when the clients’ goals were compatible with what the healthcare professionals thought the clients’ goals should be.

“It’s easy to be patient-centred when you agree with the patient’s goals and wishes.”

Healthcare professionals indicated that, despite advances in the philosophy towards care of clients, they were still struggling with the concept of client-centred care.

“So they [clients] have to be a minimum of partner and ideally they should be the ones steering the care and they should be directing us. We’re still working on that. We haven’t reached that level yet.”

#### **4.3.2 Provision of Emotional Support**

During the focus groups we asked the participants to comment on the lack of emotional support identified in the client focus groups. The healthcare professionals realized there were unmet emotional support needs of their clients.

“... I mean they should have that opportunity to articulate them [decisions] and sometimes you know, you’ve got that one hour, you’ve got a few crises, but taking the time to listen is difficult, but important.”

Interestingly, healthcare professionals identified a lack of professional training or expertise as part of their challenge to provide emotional support to their clients. Healthcare professionals didn’t feel their education had prepared them to deal with others’ emotional problems; they saw provision of emotional support within the traditional role of social work, psychology or chaplaincy.

“I know... we don’t try and get, I mean we do provide emotional

support in the sense where we relate to them to a degree, not completely, but we certainly don't try to counsel them more or get involved in that aspect because we certainly don't have training. It's not our domain, right. We can get into trouble."

The healthcare professionals also said that when they had previously addressed emotional needs of their clients they found it very 'draining' emotionally and there were no supports in place for them as caregivers. Also, addressing emotional support needs of others was sometimes more easily left to others because of the difficult nature of the task. That is, it was emotionally easier for the healthcare professional to ignore the issue.

"I think why people [healthcare professionals] don't ask and why people don't offer emotional support, which isn't necessarily counseling... is because it hurts too much so there is a protective mechanism."

### 4.3.3 Advocacy Role

In instances where there are barriers to clients and/or families undertaking an advocating role or where there are no family members, the need for advocacy was also identified as being an important function for healthcare professionals.

"...people who are more marginalized or people from different cultures or maybe English as a second language, maybe they are not as able to advocate for themselves quite the same way as others and so are they missing out on services as well? So I mean there is this

large group of people who don't have quite the same access to health care."

"Going back to this whole you need family members to advocate, I mean we live in a city, which is so multicultural and English isn't everybody's first language, they have a hard time advocating for anything."

"But I really do think that as a team we would really need to advocate for those kinds of patients..."

Healthcare professionals suggested that they were happy to perform this advocating role for their clients. However, there were drawbacks to undertaking this additional role. These drawbacks included personal frustrations and time taken away from what would be their regular responsibilities.

"I've had to write letters to ... places to say why this person should have services in their hospital...and you don't mind doing that for the patient but it is frustrating when your time could be spent doing things that would be more useful if there was some common sense in the world!"

"But doesn't it make you feel bad to sort of have to almost like feel like you are groveling or harassing like these words you know as a professional. You are making a professional opinion and you've gone and like hound them almost. I was talking to a resident yesterday or this morning... and she is like yeah I kept on calling the doctor's office again and again and again;

and it's almost like the squeaky wheel you know, gets something and anybody else who doesn't advocate or harass or hound, they don't get anything out of the system."

#### 4.3.4 Decision-making

When it came to making decisions regarding clients' rehabilitation programs, healthcare professionals struggled with their role in the process.

"Maybe our focus needs to be helping the patient make the best possible decisions or, you know, for them and for within the constraints of their disease and making them as educated as possible about the disease and what their expectations should be."

"...at least my role is just to make sure, like I can feel like I do have some control in sort of saying you know this person is not safe... it is, I think a team decision."

Healthcare professionals' respect for the autonomy of their clients was juxtaposed with concerns for the safety of their clients.

"I have a lady right now... she can decide to do whatever she wants, but, and it's taken me about three or four years to learn this but I've got to the point where you know when I am seeing a 79-year-old person that's lived a very full life and is so happy being independent and is going to fall as soon as she steps up the first step but I say, 'you know you're really unsafe,

you should use a cane but I can't make you.'"

"Even in places where we think we are pretty patient-centred, when the patients' goals and wishes are something that we think in our better judgment than theirs', it puts them at risk or you know, then what do you do? How far do you go to have the, you know to allow the patient to leave the care if you know that or if you think that they are going to be at risk for some of the things that they want to do or don't want to do? So, it gets hard."

"I think there is a reason why everybody wants to do what they want to do and having, not so much for the younger population, but I find that they're, they, they somewhat have an understanding why they probably shouldn't do it but they are still going to do it and if they're happy, why not?"

Healthcare professionals also expressed concerns about placing themselves in situations where they could be legally liable if their clients put themselves in situations of risk and something deleterious did indeed happen. In these instances, the respect for autonomy of clients was challenged by the professional accountability of healthcare professionals.

"...there are things you[ve] absolutely have to do in terms of safety; you know, we're all told that's your primary sort of goal, to make sure that if all else fails, at least they're as safe as you can make them. Liabilities will prove it, if they are not."

“I think there is an issue of liability there though. I mean, you know if you do not do everything you can possibly do to make sure somebody is safe to go home, it falls back on you if that person goes home and they fall.”

#### **4.3.5 Characteristics of Healthcare Professionals**

Healthcare professionals identified three key components of characteristics of healthcare professionals that enable one to practise in a client-centred manner. These three key components were knowledge; level of experience and expertise; and the ability to empathize. At first glance, these components do not appear as though they would present challenges and struggles for healthcare professionals. However, particularly with the ability to empathize, healthcare professionals did describe challenges.

From the perspectives of the healthcare professionals, it was important that knowledge included an understanding of the diagnosis of the client as well as an understanding of the client in a ‘broader’ context. The following quote illustrates how knowledge of the client should include more than an understanding of the diagnosis of the client.

“I think there is a real value to a physiotherapist knowing and understanding a little bit about the psychosocial issues and the social worker understanding a little bit about what is physical rehabilitation and you know and so then the patient really feels understood.”

Level of experience and expertise was identified as a critical characteristic of

healthcare professionals that enable one to practise in a client-centred manner. Healthcare professionals referred to clinical level of experience and expertise as being critical to caring for their clients. However, a personal perspective of experience and expertise of healthcare professionals was also described. Healthcare professionals defined this personal perspective as the ability to recognize one’s limitations and possessing a certain level of maturity to allow oneself to relate to clients in a client-centred manner. When the following statement was made the healthcare professional was referring to the importance of clinical experience and expertise and their effect on quality of care.

“What kinds of quality rehabilitation you can do if you don’t have experienced staff is really, really limited.”

The next two quotes address the personal perspective of recognizing one’s limitations and having a maturity level to deal with these limitations and to centre the treatment around the client.

“[Healthcare professionals] have enough expertise to feel comfortable in what they can offer... because the people that work with the people with chronic illness have to be comfortable that they can offer what they can and if their ego is built on things fixed, they’re in the wrong field...”

“... a lot of it comes from life experience... so a certain amount of maturity would be helpful.”

Maturity of healthcare professionals was referred to in the context of respecting

decisions of clients as well as dealing with difficult situations that are often experienced with chronic and progressive illnesses.

The ability of healthcare professionals to empathize was identified as a critical characteristic to enable client-centred practice. Empathy is an important component of successful interpersonal relationships and this is illustrated by the way one healthcare professional described such an interpersonal relationship.

“Someone who is good is someone who listens, incorporates what are the priorities for me, within the context of what’s reasonable.”

Focus group participants identified challenges with the ability to empathize because they felt it is not necessarily something that one can learn.

“I don’t think empathy is something, a built-in, a natural thing for people and when people develop empathy even through having experiences that allow them to suffer, give them that gift ‘cause I don’t think we can develop the wisdom to be empathetic.”

“Well, I think one thing that is really difficult is we don’t have any training in [empathy]... I don’t believe that you can really put yourself in the place of the patient and say ‘oh you know...’”

#### ***4.4 Restraints Imposed by the Healthcare System***

Healthcare professionals identified numerous restraints related to the structure, processes and inner workings of the healthcare system that posed challenges for practising in a client-centred manner. Healthcare professionals proposed that these restraints were based on policies within institutions as well as government policies, related to healthcare. Within institutions, policies that imposed restraints were described at the organizational level as well as the program or unit level. Participants described a bureaucracy that is “fact and workload measurement obsessed.” Restraints imposed by the healthcare system, according to healthcare professionals, ultimately affected individual clients and the care that they received. The healthcare professionals felt that many times the goals were not client goals or healthcare professional goals, rather they were organizational or system-level goals.

“I think the goal is to have them organized around the needs of the clients but the needs of the clients haven’t been really determined by the client. The needs of the client have been determined by whoever runs the show, basically, a combination probably [of] the program and then the hospital... it’s not just based on what professionals think the patients need – it is based on probably a lot of other things like, you know, are the resources available?”

“I would say it’s administrative issues that from my perspective really get in the way the most of

the client/family-centred service because I think all the clinicians are on board and really support the notion of client/family-centred practice but when we have to play the numbers game and they're seeing that you know these other disciplines can see twice the number of clients that you see over a shorter period of time then it, it puts us in a dilemma."

"I think we've had a healthcare model that was built on acute care."

#### 4.4.1 Access and Eligibility Issues

Healthcare professionals described access and eligibility issues from two main perspectives. These perspectives emphasized the importance of equal access for all as well as the limitations experienced to equal access.

"And I think ideally if there was equal access for all. ...people who are more marginalized or people from different cultures or maybe English as a second language, maybe they are not as able to advocate for themselves quite the same way as others and so are they missing out on services as well? So I mean there is this large group of people who don't have quite the same access to healthcare."

Equal access is important because of variations in social and financial means.

"We need to focus on ability not disability... so I think what really works is when we do have the opportunity to use a continuum of care to support those abilities

and that the care is seamless so you're not always running into barriers, whether financial or access issues. It should be seamless – people should be able to just move on and use those abilities constantly."

Limitations in access to the healthcare system and rehabilitation were also described. A main feature of access issues was the importance of the timeliness of an intervention. These limitations were contradictory to the concept of client-centred rehabilitation because the needs of clients are unmet for various periods of time.

"We are looking at the major issues seen right now, inadequate access to care, inadequate timing to that access to care. There is not enough man power... There is no long term delivery planned, it's all short-term intervention and yet we know there is a need for revolving door policy with our patients because the diseases aren't cured, like MS. ...But the timing of those steps is uncertain so you can't even plan for a monitoring program that fits when somebody flares and the current system is not adaptable; it does not adapt to the chronic patient and most therapy in the community is delivered, what 15 sessions, and then that's it and our patients need long-term monitoring care time and timely intervention. We use hospital resources if we can get them. It's rare that I can get somebody to see a therapist here. We use the Arthritis Society, social worker, PT, OT a lot with their manpower to completely stretch and probably the best access I



have is if I have a third party payer. We can usually get a private practice therapist tomorrow, which is when you really need it.”

“I think you know, globally in Ontario and specifically to the GTA, we need to look at in terms of you know what facility provides what, what are the needs, what are holes and look towards coordinating it so that everybody that needs rehab’ services can access them in an equitable and fair manner, in a timely way.”

Waiting lists for various levels of care as well as services in the community often act as a restraint to delivery of client-centred rehabilitation. Geographical variations in services across the Province were also described which affected access to service within one’s own community.

Clients who are eligible often have to wait for various programs because of a lack of availability. In addition, there are those who do not meet eligibility criteria, but could benefit from rehabilitation.

“A lot of people want to leave with attendant care and it is not available so there is, there’s quite a backlog of patients who would go home or who would leave hospital if there was a place for them to go.”

“The outpatient programs are so specific with their eligibility and criteria who they will take. It’s impossible to get someone in unless they have a definite stroke diagnosis or a... definite head

injury diagnosis. Anyone with Guillain Barré, Parkinsons, they really can’t get into an outpatient rehab type facility where they could look at setting goals and working towards something.”

“...they need rehab’, they want, they are motivated and they want to go to rehab’ but they don’t seem to be an appealing rehab’ person you know, and because the wait list on the rehab’ side is so long, they want to pick through people that obviously can get through their four to six weeks length of stay as well. So they are picking and choosing...”

“By the time you qualify, you are really pretty good to go. They won’t accept anybody who truly needs rehab and has lots of rehab potential that will be complex because it will... affect their length of stay...”

#### **4.4.2 Transition and Continuity of Care**

Closely related to access to and eligibility for services is the transition process. Healthcare professionals described the importance of a smooth transition process from one level of care to another. Their descriptions included tasks they undertook to ensure a smooth transition as well as problems they encountered with the process of transferring from acute care to rehabilitation; rehabilitation to outpatient therapy or day hospital; and outpatient therapy or day hospital to community-based supports. Many descriptions of the problems with transition at these levels revolved around system-level issues, inability to access community

resources or unavailability of community resources.

“...often I am scheduling people before they come that I know over the course of the week who is going to come on what days. On our acute side I will often go and visit them on the acute floor, just to help them make the transition. They’re also giving them information in terms of rehab’, what to expect, to get them to bring in clothes and footwear and things like that. So, you can answer some of their questions because it is often fearful for them to make that switch from one place to another.”

“So looking toward the end of day hospital, linking them up with either seniors’ exercise groups or social groups or recreation groups or a few of the nursing homes offer day programs so if they are going home but their family are sort of worried about the burden of care that they’ll often have them out on visits to these day programs that can free up the family a little bit when they finally get home.”

In contrast to the ideal transition processes described above, healthcare professionals described barriers to a smooth transition from one level of care to another. The presence of waiting lists is evidence of a lack of the timeliness that was previously described as being so critical to client-centred rehabilitation.

“We’re having difficulty now with sending patients to rehab’ ‘cause the waiting lists are huge

... I’d say probably it’s gotten worse over the last two to three months where before we would send an application and within three days, we would get a bed. Now their wait list is like three weeks.”

“So someone is being discharged from rehab and you have to wait for six months to get a personal support worker; well they can’t live in the community without that because they can’t get dressed, they can’t get bathed, they can’t be toileted...”

Inclusion of the client in the discharge planning process is critical.

“For all of our outpatient programs we did a patient satisfaction survey ... the one thing that people consistently identified, it didn’t matter what program they were in, ... all the lowest score[s] was the patients didn’t seem to know what to do once they were discharged from the service.”

#### 4.4.3 Lack of Follow-up

Follow up is a critical component of the transition process. During previous focus groups with clients, they reported follow-up to be a missing link. Clients described being “dropped like a brick” (Cott et al, 2001). We told the healthcare providers about this and asked for their comments. They agreed that follow-up was something that clients *need* and also something they often were unable to provide. Follow-up was seen as an integral component of a continuum of care that would not stop at time of discharge from either inpatient or outpatient rehabilitation.

Follow-up was thought to be most critical for clients with chronic and/or progressive conditions such as spinal cord injury, multiple sclerosis, arthritis, and acquired brain injury. Healthcare professionals identified barriers to follow-up as a lack of resources, both financial and human.

“One of the things we don’t do that we can’t do, I think, it is a resource thing, that we’d like to do, is that follow-up piece. It works well at the time of discharge and maybe that one month follow-up but has it worked well at six months? We are not sure.”

“I really struggle with how we follow up our patients. I don’t think we’re able to. I think sometimes we should. I know from an accreditation standard, you know about after transition or end of service do you follow up and I’ve heard many of us saying we’d like to do it. How do you do it? And so with resources in the system, because I really think that’s why people have the perception they are being dropped, even if they are not. There isn’t that follow up from the people that know them and where they are at this point in time.”

“I think ... short-term is understood in rehab, but long-term there is no definition... For chronic conditions... The resources aren’t there. I mean I don’t think the funding is available for the follow-up the long term; it’s, you know, all the

dollars are at the front end of rehab.”

“One of the things we haven’t done but would like to do is try and bring the people back because it is supposed to be a self management kind of skill set building; it would be great to be able to bring them back and see if they are maintaining any physical improvements as well as some of their quality of life issues that we’ve measured... but we’ve never had the opportunity or resources to go back and evaluate it...”

Healthcare professionals indicated that they thought patients *want* and like the continuity of staff, that is, follow-up with staff who know them and their issues.

“I think [what] my client[s] feel good [about] is the continuity of staff... They feel that they’re somebody who knew what they were like, who has an understanding of the family, the work problem, the physical problem... You know that I think health care is a very human side, it’s a personal touch.”

When asked what a perfect rehabilitation system would be like, one participant described the importance of the continuum of care which includes follow-up. The importance of the ability to re-enter the system was highlighted. Re-entry into the healthcare system was described at the acute care level but also at other levels. Healthcare professionals pointed out that re-entering at other

levels of care helps avoid the expensive costs of an acute care level of healthcare.

“[A perfect rehabilitation system] would be a continuum of care that would start in acute care if that is where it needs to start and it would address all of the client’s needs and family needs and they would be addressed as the patient moves through the continuum of care and that would not stop at discharge from rehab. It would continue on into the community and sometimes the patient would enter back into acute care and go through again... the continuum needs to involve very much the community services...”

“And this ability to re-enter as required is really quite important... as far as the cost is concerned, if there is timely re-entering to all of the care then you are actually going to put out a lot of clients. And I think it would be cost savings in the long run because then if you are preventing people from re-entering into an acute stage then that’s saving dollars, if people have the option of coming into the system as they need it, and they know best. Clients know best when they need to have the services again.”

Re-entering the healthcare system was identified as an integral component of follow-up. This importance is based on the fact that some conditions are life-long and as people age, situations change.

“There is always that other group though that go home who haven’t significant injury but they got discharged from some private services or some home care and there is nobody officially following them, nobody who really even knows them well from in hospital ... Their life situation changes or something about them changes to make it become a real need again where they have to enter the system again but nobody really tracks or helps them. They just have to fight the system to try and get some services, something you know, for instance the spinal cord person with a shoulder injury now because they’ve used their arms so much to move that wheelchair... They are out of the loop. There is nobody following them for life even though this injury has followed them for life.”

“I was just talking to my friend who works in CCAC and she is telling me how she’s got patients; once they are at home, it is so hard to get them back into rehab’ ... So even the community, the people who are working in the community, I feel they don’t have any support either. So, I can only imagine what the clients are feeling... I think it comes down to budgets...”

#### **4.4.4 Workload Issues**

Healthcare professionals also described other issues of an organizational nature that contributed to barriers to practise in a client-centred manner. These included

inadequate staffing levels, heavy workloads, and time constraints imposed by these. Reasons for workload-related barriers were attributed to budgetary constraints and lack of available personnel. Inadequate staffing affected the amount, as well as the range of services that facilities were able to provide. Program development and expansion were difficult to consider in the face of inadequate staffing.

“So the staffing of the team is up and down depending on the financial situation of the hospital...”

“...staffing has been a big issue recently, more recently like in the last couple of years.”

“...we’ve never been in a position to be asking for more. It is sort of making do with less... and then because of cutbacks but then more recently it hasn’t been financial constraints as much as staffing constraints and you know you can’t expand what you are doing when you can’t even do everything you’re supposed to be doing.”

With inadequate staffing comes increased workload and time constraints for those healthcare professionals who are caring for the clients. Healthcare professionals described adaptations they employed in their schedules such as prioritizing of clients to be seen and the personal challenges and frustrations that come with such prioritizing.

“Coming from a social work’s perspective... the ideal for me as a social worker would be to

provide most if not all patients with support, support counseling, and emotional support... realistically speaking some patients do get a lot of the support; others probably get minimal, only because caseload and you learn how to prioritize your work.”

“Caseload demands and financial restraints and not having enough staff to cover the increased caseloads. That makes it tough... complexity of the caseloads... and other responsibilities.”

“So even if I had time to see a person perhaps I couldn’t get the time of someone else to help me so then that falls by the wayside again. So you tend to just focus on ‘okay well I don’t have time today to see this person because I need help and I don’t have the help. I’ll see this person who is a one-person assist so I can work with them or this person is going home’ so then the priority gets shifted again and then so unfortunately some people do fall by the wayside because of lack of time.”

“We end up picking up somebody else’s caseload or part of their caseload and how do you decide which patients are more important?... It gets really tough.”

#### **4.4.5 Space Issues**

From an environmental perspective healthcare professionals indicated that

space restrictions often imposed barriers to practising in a client-centred manner.

“One of the things that we face on our floor because of the environment where we share space with the [Alternate Level of Care] ALC patients... A lot of the ALC patients are noisy and very cognitively impaired and immobile and I think that would be their biggest frustration that you often hear comments about it being noisy at night and not being able to sleep or even emotionally looking at these other patients and thinking I am not that far away from being that person... I think that is quite disturbing.”

“I would think the space thing would come up from our patients that the rooms, when the hospital opened there weren't designated rehab' beds and it's so they are on sort of a medical floor in terms of space, that the washroom isn't you know the best layout in terms of someone managing independently, in and out of the shower. The space within the room isn't meant to have a wheelchair and a walker and everything else. So you know their access is limited because of space as well.”

#### **4.4.6 Multiple Demands**

Healthcare professionals described a working environment where they were balancing multiple demands. These demands included goals related to both the client and the institution. With respect to their clients, healthcare

professionals described the struggle of balancing meeting the needs of incoming clients and following up on previous clients.

“So when you have time and when you have that flexibility you can really work on your goals in more client-centred ways. But, when you don't have the time or the staffing, then I think a lot of times people have things done for them especially in a hospital, which isn't part of their rehabilitation process.”

“When they are discharged... they don't really know where to turn if their problem occurs... we've always functioned in a model where it has to be time limited or ... you can't move new people into the system to provide the services so that ... we have to somehow find a method to balance ... getting everybody through that needs the service but also providing ongoing contacts ... it's hard to imagine how you can do it.”

Flexibility by healthcare professionals to adapt to immediate needs and concerns of their clients was identified as being important to practising in a client-centred manner. To be flexible, healthcare professionals realized this involved a process whereby they prioritized the multiple demands placed upon them.

“I mean you know we are on a schedule and they want to talk but what is more important the talking for 15 minutes or stretching that tight joint, I mean

you know you've got to be a little flexible at the right time.”

In summary, through the focus groups and in-depth interviews, participants described client-centred practice from the perspective of the healthcare professional. These descriptions compared and contrasted the ideal with reality. Healthcare professionals, very eloquently, acknowledged the value of their clients' participation in the rehabilitation process. Healthcare professionals also attempted to provide an insight into what they perceived to be challenges and struggles that clients encountered which were counterproductive to a client-centred approach to rehabilitation. Challenges and struggles on the part of the healthcare professionals were also presented. They provided evidence of abilities to self-analyze their role in the process of client-centred rehabilitation. Finally, healthcare professionals provided a constructive description of barriers at the system-level, with references to government as well as institutions.

## **CHAPTER 5: COMPONENTS OF CLIENT-CENTRED REHABILITATION**

The objectives of this research project were to further develop the definition of client-centred care as it applies to rehabilitation, identify client-centred parameters for rehabilitation programs and identify criteria for evaluating the extent to which various rehabilitation programs are client-centred. As did the first phase of this research project, our findings indicate that client-centred rehabilitation is much more than goal-setting and decision-making between individual clients and healthcare professionals. It refers to a philosophy or approach to the delivery of rehabilitation services that reflects the needs of individuals and groups of clients. This analysis both confirms and furthers the understanding of client-centred rehabilitation from phase one of this research project with clients.

From the perspectives of healthcare professionals, client-centred rehabilitation places a high value on the participation of the client. Healthcare professionals also identified challenges and struggles at various levels, including the client, the healthcare professional and the system, to client-centred rehabilitation. From the themes that were identified, in combination with the literature review, we identified the following components of client-centred rehabilitation that should be considered throughout the rehabilitation continuum.

### ***5.1 Family Involvement***

When applicable, it is of utmost importance that family members be

involved in the care of clients. Family includes anyone the client considers to be a significant relative, friend or neighbour, regardless of biological or legal relationships. Families offer both tangible and intangible resources to the client-centred rehabilitation process. For example, they may be a source of emotional support, as well as physically assisting with the actual care. It must be recognized that families may be willing and/or able to participate to varying degrees and it is important that this level of participation is understood and agreed upon by the client, family and healthcare professionals. The corollary to family members *giving* of themselves to the process is that they also have needs that *require* support. This support may be in the form of education, emotional support and physical help with care giving.

### ***5.2 Client as 'Equal'***

Open, communicative relationships, where the client is considered an equal partner in the client-healthcare professional relationship is critical to client-centred rehabilitation. Application of the traditional hierarchical biomedical model where the client's participation is minimal is not compatible with a client-centred rehabilitation approach. Models for the client-healthcare professional relationship that respect the autonomy of the client and attempt to understand the values, both health-related and otherwise, promote the concept of the client being treated as an equal partner. This process of empowerment of the client is important for maximizing client participation in the rehabilitation process.



### ***5.3 Goal Ownership***

It is widely recognized in the literature regarding client-centredness that goal-setting is an integral component. Healthcare professionals in our focus groups confirmed this notion. However, they emphasized that it is important to determine the ownership of such goals. ‘Whose goals are they anyways – the organization’s, the healthcare professional’s or the client’s?’ For goal-setting to occur in a manner that is truly client-centred, the goals must be those of the client. It is recognized that there may be limitations within the organization or from the perspective of the healthcare professional to achieving goals. However, the important aspect of goal-setting is that despite any limitations that may exist, the client’s goals remain the focus of the relationship between the client and the healthcare professional. Central to the client’s goals is the fostering of hope. Goals may not be immediately achievable. However, healthcare professionals recommended, for example, dividing large goals into smaller achievable components, in order to foster hope. It is also important to recognize that goal-setting is a dynamic process that requires renewal.

### ***5.4 Client as Team Member***

Inclusion of the client as a member of the traditional healthcare team is also an important element of a client-centred rehabilitation approach. Inclusion of the client as a member of the team is compatible with the empowerment of the client previously discussed. Potential benefits of including the client as part of the healthcare team are maximization of

the participation of the client in the rehabilitation process, increased understanding of the rehabilitation process by the client and development of a system for information-sharing amongst clients and healthcare professionals. However, it must be recognized and respected that the level of participation by the client on the healthcare team may vary depending on the client’s readiness to participate in rehabilitation. Readiness to participate may depend on such items as acuity of the client’s condition, their readiness to be part of the team, their level of understanding, and their physical, emotional and cognitive ability to participate. Practically speaking, among other inclusions, including the client as a member of the team would involve the client being present at team meetings. Another consideration is that family involvement may be increased when client’s readiness to participate is minimal.

### ***5.5 Philosophical Shift in Healthcare Professionals’ Approach to Care***

Healthcare professionals recognized that clients are not always seen as ‘equals’ in the client-healthcare professional relationship. One of the causes that was put forth for this imbalance was a lack of training for healthcare professionals regarding a client-centred approach. Healthcare professionals, most often described an educational background that was based on the traditional biomedical model. In order for client-centred rehabilitation to occur, there needs to be a philosophical shift in the approach to care. Education of healthcare professionals about client-centredness is critical. This education is required on at least three levels. These

levels include the undergraduate level, graduate level and continuing education.

### **5.6 Information-sharing**

A second reason that was put forth as an explanation for clients not having equal weight on the team was because they had an imbalance of knowledge. In order to gain knowledge about their conditions, clients must *receive* information. The content of the information must be at a level understandable to the client and delivered in a timely fashion. This process is synonymous with the problem-solving component of shared decision-making described by Deber (1994). Establishment of an environment conducive to clients *giving* information to healthcare professionals is also critical to both the information-sharing and decision-making processes. In order for healthcare professionals to facilitate a client-centred relationship this necessary information provided by clients is extremely valuable.

### **5.7 Emotional Support Provision**

Healthcare professionals agreed with clients on the issue of unmet emotional support needs. Simply, emotional needs of rehabilitation clients were often unmet. Healthcare professionals identified two reasons for unmet emotional support needs of clients. A lack of professional training or expertise in the area of emotional support was identified. The ability of healthcare professionals to empathize was also considered important to entering into a client-centred relationship. Formal training for healthcare professionals to learn to provide emotional support to clients is necessary to alleviate this

apparent void. This training does not require advanced counseling or coaching strategies. Focusing on listening, one of the basics of communication, was identified by healthcare professionals as absolutely critical to being emotionally supportive. The ability to show empathy and foster hope, in a concerned and caring manner, is paramount to client-centredness.

The second reason healthcare professionals gave for their inability to meet the emotional needs of their clients was that healthcare professionals, themselves, also require emotional support. It is unrealistic to expect healthcare professionals to be able to emotionally support their clients in a client-centred way, without provisions for them to receive emotional support regarding situations that are often emotionally draining. These provisions for emotional support for healthcare professionals are the responsibility of the organization.

### **5.8 Decision-making**

Struggles healthcare professionals described with their roles in the decision-making process often were secondary to safety concerns for their clients. Safety concerns ultimately were manifested in professional liability concerns. The shared decision-making model proposed by Deber (1994), where the healthcare professional is a key to the problem-solving component, provides guidance for healthcare professionals to resolve such dilemmas. Taking the time to provide the appropriate content of information in a timely fashion is a critical foundation for the next stage of shared decision-making. It is acknowledged that clients

may choose unsafe options despite excellent information-sharing. However, attention to the details of the shared decision-making process clarifies roles in the decision-making process.

### ***5.9 Access to Rehabilitation Through More Than One Door***

Access to rehabilitation services was identified as a key component of client-centred rehabilitation. Access means getting services that are needed, at the time they are needed and at the level of care that is appropriate. The front door to accessing the rehabilitation system should not be through acute care, unless this is the level of care required. Access to rehabilitation should be via the level of care that is required. Eligibility of clients for rehabilitation services should be based on their need and not on their predicted length of stay.

### ***5.10 Follow-up as a Continuum of Access***

Healthcare professionals also agreed with clients regarding the *need* for follow-up. Follow-up is a critical component of the seamless transition process between and after all levels of care, especially needed for chronic conditions. Follow-up requires coordination and communication amongst healthcare professionals at all levels of care.

### ***5.11 Environmental and Organizational Considerations***

Overall, there are multiple demands placed on healthcare professionals. Meeting the needs of incoming clients and following up on outgoing clients is a challenge, in combination with meeting

the needs of the organization. Workloads of healthcare professionals must allow for flexibility to meet the individual needs of their clients, such as taking extra time to listen. From an environmental perspective, appropriate space is important to accommodate individual clients and their needs.

It is reassuring to learn that there are significant similarities between what the clients considered important to a client-centred approach and what the healthcare professionals considered important.

## CHAPTER 6: IMPLICATIONS FOR FUTURE RESEARCH

Our findings provide support for several of the directions noted in “Managing the Seams: Making the Rehabilitation System Work for People” (Provincial Rehabilitation Reference Group, 2000).

1) “A new method is needed to replace current program-funding models in order to be able to do system-wide planning; a system based on spaces or places rather than beds still needs to be rationalized from a funding perspective. Several jurisdictions have begun to develop a framework for classifying spaces within the system according to different levels of client need (including the HSRC 1998). Based on this work, spaces would be grouped according to several criteria:

- the type of impairment, activity limitation and/or participation restriction;
- the severity of impairment, activity limitation and/or participation restriction; and
- the expected duration of the rehabilitation process during which services will be needed.

Using these criteria, client need for rehabilitation services can be grouped into three broad categories: Acute, Continuing and Episodic.”

Our findings suggest that rehabilitation eligibility should be based on need. Steps must be taken to take the needs of clients into consideration when addressing the

services offered by rehabilitation facilities. This will require:

- further research to review the evidence available that determines need for rehabilitation;
- further research to identify unmet rehabilitation needs due to ineligibility;
- education of the public to increase awareness of availability and services offered by ambulatory care services to minimize strain on unnecessary utilization of higher levels of care such as inpatient rehabilitation; and
- adoption of standardized admission and discharge criteria utilized by institutions.

2) “From the client perspective, a client-centred system is one within which clients are actively involved in managing their health care and their rehabilitation process, and in setting individually-appropriate goals in partnership with service providers. Research shows that there is an important relationship between clients’ involvement in goal-setting, their sense of control over the overall process, and health outcomes”.

Our findings concur with this synopsis of client-centredness. To achieve this type of a system the following would be required:

- education of healthcare professionals, at the undergraduate, graduate and continuing education levels, regarding client-centredness and a philosophical shift away from the traditional biomedical model;
  - allowances within the system to accommodate the flexibility that is required of healthcare professionals to provide client-centred rehabilitation; and
  - standardized use of outcome measures such as the COPM to measure the degree of client-centredness.
- 3) “There is an acknowledged need for multiple, clearly identifiable access points into the rehabilitation system that are clearly communicated to clients, referral sources, and professionals. Where appropriate and possible, clients would be able to choose an entry point into the system that best fits their needs.”

criteria and application procedures.

Our findings also support this ‘access through more than one door’ to the level of rehabilitation care that is appropriate. This would require:

- standardized revision of eligibility criteria for various levels of care; and
- education of healthcare professionals at various levels of care of these eligibility

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