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Empowerment in medicine: An analysis of publication trends 1980-2005

Research article

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Abstract: This paper draws attention to the rapid increase in the number of published articles in medicine devoted to issues of empowerment. While our main aim is to identify populations to which empowerment has been applied, we have also offered a brief overview of the literature. A Medline search was used to identify all articles relating to empowerment published between 1980 and 2005. A total of 4496 articles were identified, but after the deletion of articles with non-human applications (n=409) and those published in languages other than English (n=145), a total of 3942 were reviewed. Based on this review, we present a taxonomy of the literature, based on the primary foci, including patients (n=1742, 44%), providers (n=1162, 29%), and society (n=1038, 27%). Over the study period, we document a rapid increase in the numbers of articles devoted to all three categories, but a significant increase in the proportion of papers devoted to patient empowerment ($P < 0.0001$). We conclude by juxtaposing some recent European health care policy reforms that have had mixed consequences for the empowerment of patients and argue for a more scientific approach to the study of empowerment.

Keywords: *Empowerment • Patient empowerment • Publication trends • Health policy*

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1. Introduction

In recent years the term 'empowerment' has become a catchphrase in academic medicine and the concept has been applied to a range of populations and settings [1-10]. Empowerment has been studied in the context of quality improvement, health care policy reform, health care ethics, consumerism, philosophy, partnerships, psychology, and information imbalance [11]. Parallel literatures have also examined how patients can become empowered through shared decision making and self-management of therapy [2,12].

The textbook definition of empowerment relates to the granting or giving of authority, strength and confidence – produced by physical or financial means. Throughout history, empowerment has often served as the basis of a counter movement to overcome economic, political, religious and racial disparities. Today, empowerment has a broader meaning which especially focuses on self-realization and self-help. With regards to social policy, empowerment can be seen as a counter movement to paternalistic attitudes of the social welfare systems developed during the 20th century.

In the medical literature, a widely-accepted definition of empowerment remains elusive [13]. Despite this, empowerment universally carries a positive connotation, belonging to a class of similar positive constructs such as patient activation, self-efficacy, self management, and patient autonomy. The foundation of the modern medical literature on empowerment can be found in the

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seminal works of Rappaport [14,15] and Zimmerman [16,17]. Rappaport stressed that empowerment is easier to define in its absence; *viz*. through the eyes of the unempowered [14]. This said, the very notion of empowerment provides a constructive framework for developing interventions in which participants become important stakeholders [15]. For Zimmerman, empowerment could be conceptualized at different levels of society: for individuals, organizations and for communities [16]. Zimmerman also stressed the importance of differentiating between the processes and outcomes associated with empowerment [17].

Despite these seminal works, and the rapid growth in applications of empowerment in medicine, the literature remains unorganized. This review aims to draw attention to the many applications of empowerment in the medical literature and to numerate both the increased focus on empowerment and to identify the various populations to which it is being applied.

In considering the policy implications, we find that empowerment has become the *modus operandi* for increasing the efficiency of the health care system for some European health care policy makers, but many European nations remain entrenched in paternalistism. We argue that the merits of either approach require a more scientific approach to empowerment, especially when it comes to identifying the degree to which the general public is empowered in health.

2. Material and Methods

We searched Medline for all articles (including original research, reviews, editorials and letters) published between 1980 and 2005 that contained the root word "empower" (e.g., empowerment, empowers, empowering, etc.) in the title or abstract. This totalled to 4496 unique articles. Few articles were published before 1980 on empowerment and were deemed not to be reflective of the modern literature. Given the breadth of various literatures that interact with the literature on empowerment, and the vast numbers of papers already under review, we did not perform secondary literature reviews or searches of other databases. We excluded papers focusing on non-human applications (n=409) and those published in languages other than English (n=145). All remaining articles (n=3942) were included in our study.

An initial abstract review was conducted to review and categorize the papers. The papers were sorted by publication year. A decision was made to not conduct a separate country classification analysis due to a potential bias, given the English language inclusion criteria. We categorized the literature according to the primary stakeholder for which empowerment was being discussed. Three primary stakeholders were identified: (1) patients, (2) health care providers, and (3) society, relating to broader issues of empowerment.

A second stage article abstraction was then conducted to identify important sub-categories relating to the empowerment of patients and providers. The numerical analysis focused on the annual total number of papers published in each of our three main categories. These data are graphically presented, illustrating trends in the data. An ANOVA, with a Bonferroni correction, was used to test differences in the proportion of articles focusing on patient empowerment, comparing articles published prior to 1987 as compared to the remaining years.

While this paper primarily focuses on the numerical analysis of the empowerment literature, we also present a brief analysis of the content of each of the categories (and sub-categories) found in our study as a more detailed analysis of articles focusing specifically on patient empowerment was previously published [2]. Given the breadth of the literature and the numbers of papers involved, we did not aim to present an overview of all facets of the literature, but rather present the reader with a brief overview and a small number of readings that are particularly relevant to health care policy in Europe.

Figure 1. Selection of the abstracts in the literature review.

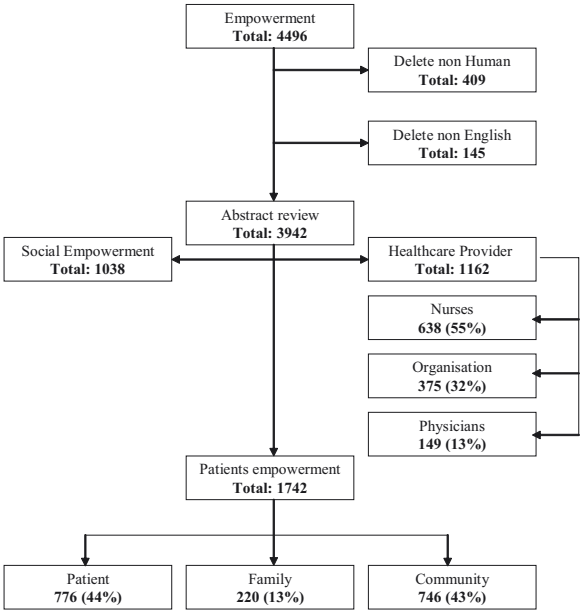
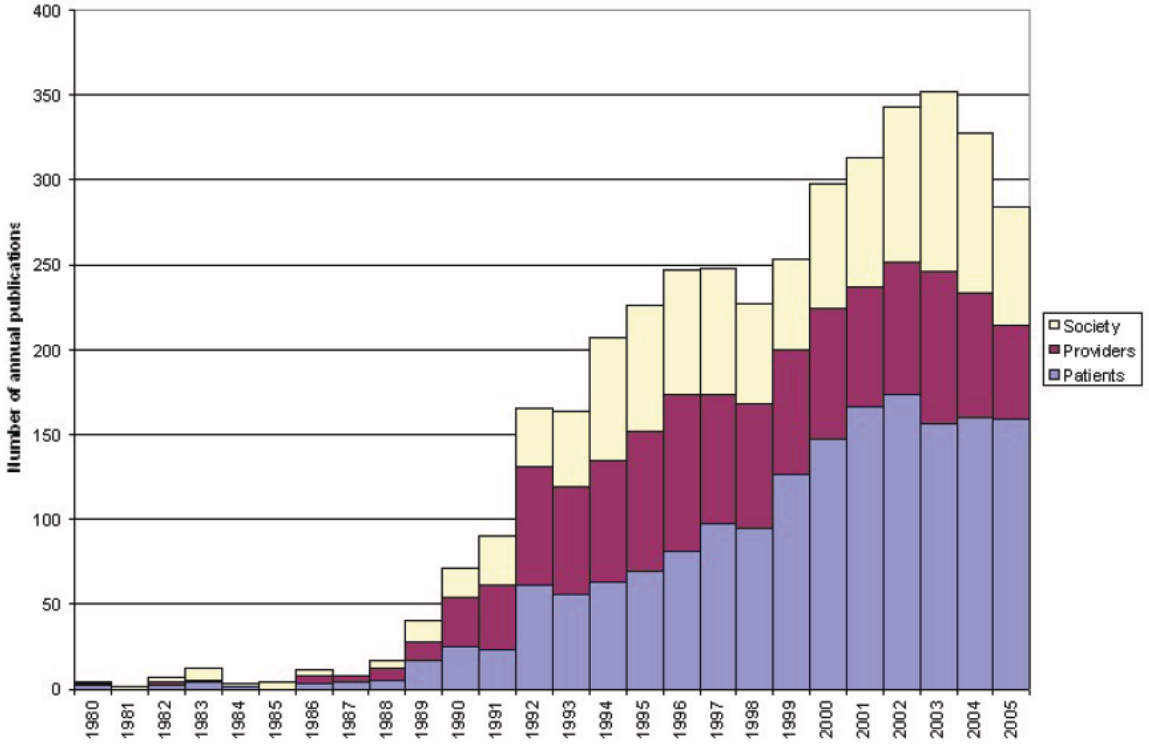


Figure 2. Rates of published articles on empowerment in the health literature by main stakeholder, 1980–2005.



3. Results

Of the 3,942 abstracts reviewed (see Figure 1), we found that 44% were related to patients (n=1,742) and 29% to health care providers (n=1,162) and the remaining 27% of papers were categorized within a broader population which we labelled "societal empowerment" (n=1,038). Upon a deeper review of the papers, the patient empowerment group was sub-categorized into articles that relate to individual patients (n=776, 44%), families (n=220, 13%), and communities (n=746, 43%). Likewise, articles relating to health care providers were sub-categorized into groups focusing on nurses (n=638, 55%), organizations (n=375, 32%), and physicians (n=149, 13%). No additional subgroups were identified in the societal empowerment grouping.

3.1. Empirical analysis

The total number of published articles by the categories of empowerment, over time, is presented in Figure 2. While all categories had an upward trend during the study period, the proportion devoted to patient empowerment grew significantly more rapidly than the provider and societal areas. In the articles from the 1980s, the concept of patient empowerment can be found in only 6% of all published empowerment papers. This changed at the beginning of the late 1990s as more interest was placed on patient empowerment (42% in 1998 and 53% in 2001.) A significant increase in the proportion of papers devoted to patient empowerment ($P < 0.0001$) transpired after 1997.

4. Taxonomy of empowerment

Given the diversity of populations and applications that empowerment has been applied to, it is important to appreciate some of the content of the papers that we reviewed. The following is a brief review of the patient, provider and societal empowerment literatures, the first two of which we have identified important sub-categories. Obviously, given the sheer numbers of papers involved, a detailed and systematic analysis of the content of all papers is beyond the scope of this paper. This said, we have attempted to shed some light on each of the categories and sub-categories of the literature on empowerment identified in this study. While we have drawn upon papers that have particular relevance to European health care policy, the European literature is not as comprehensive as those found elsewhere – particularly the USA and hence our review remains somewhat international.

4.1. Patient empowerment

As demonstrated in the analysis above, patient empowerment accounted for a growing proportion of articles during the study period. Exact definitions of patient empowerment vary, depending on the disciplinary background of scholars as well the target populations of interest [3,13,18,19]. In our previous review of this particular literature, we define patient empowerment as a *"continuous process through which patients (and patient groups) work in partnership with their healthcare system to enable patients to become more responsible for, and involved in their treatment and healthcare"* [2]

In the literature, this enabling process has been approached in different ways, and varies depending on whether the focus is on individual patients, families or communities of patients with similar conditions. We review each of the sub-groups of patient empowerment as follows.

Individual patient empowerment relates to the very personal relationship between the individual patient and their health care provider [2,19]. The literature on individual patient empowerment has focused on a number of chronic conditions [8,9], and the need for policies to promote patient control (both over their disease and their care). This literature has traditionally focused on shared decision making at the individual level [2] but in recent years it has been discussed in the context of broader policy initiatives such as the role that patients play in the evaluation of medicine and in health technology assessment [20].

Family empowerment relates to the broader perspective of patient care, involving a patient's immediate support networks (including caregivers and surrogate decision makers) and the health care system [6,12]. In paediatrics, family-focused care is a key element of program development. This is especially true when focusing on building a parental partnership with the physician. Focusing on this relationship, rather than just child health outcomes, leads to a more efficient use of the health services given that the parent is the "consumer" [12] of services. In addition, with increasing longevity, other familial relationships must also be accounted for, especially with regards to long term care and the treatment of Alzheimer's [6].

Community empowerment, as opposed to individual patient empowerment, was highlighted in the literature, focusing on groups of patients united by either a common location or type of disease who collectively take action to improve their health [10,21]. Community empowerment is distinct from efforts to address greater social and political inequities beyond the scope of health care (or what we classified as *societal empowerment*). Community empowerment was first applied in mental health, but has become more widely applied through "user involvement" and stakeholders' involvement in health care reform [22]. The aim of community empowerment is to strengthen the patient's voice, to create an environment of group support and to promote solidarity. Programs aimed at promoting community empowerment often focus on sharing knowledge among patients and to promote a more coherent voice for patients [5,20].

4.2. Provider empowerment

Publications focusing on provider empowerment discussed issues concerning autonomy, knowledge and efficiency focusing on the nurse, organization, and physician empowerment. The majority of papers in this category focused on empowering nurses, who strive to gain power (and even professional status in some European countries) in a system dominated by physicians. This said, as health care payers and regulators focus more on evidence-based medicine and cost containment [20,23], physicians and organizations themselves have been seeking to gain empowerment.

Nurse empowerment applications in the literature concentrated on expanding nurses' education, leadership skills and management effectiveness, with the aim of enhancing nursing commitment in the workplace, professional competence and job satisfaction [5]. At the same time the role of nurses in the processes of patient empowerment is broadly discussed. This literature focused on a shared power position and a realignment of the traditional power base within health care systems away from the physicians control, towards a nurse/patient dyad [5].

Organization empowerment, although less common in the literature, addressed issues of "change management" and policy initiatives aimed at improving staff performance and the quality of health services. *Physician empowerment* drew a small, yet resolute, literature that discussed the challenges in changing power from providers towards payers, and the need to manage these challenges [23,24]. Given that empowerment issues are often identified in the absence of empowerment, and that currently the balance of power is shifting away from physicians, this literature is destined to grow in the near future.

4.3. Societal empowerment

Societal empowerment applications in the literature address groups and populations who have been excluded from decision making processes because of social discrimination, isolation or chaos. Primary to this are the

plight of minority groups [25], disabled individuals [21], and high risk populations [4]. Societal empowerment papers described health policy interventions aimed at correcting imbalances in the social, economic and political environments that shape and constrain individual and societal health outcomes. Societal empowerment differs from the concept of community empowerment in that it relates to a broader social agenda.

5. Measuring Empowerment

Existing conceptual models in the literature, like community empowerment, nursing empowerment [13], family empowerment [6], or related to patients disease-specific models [7,8] define in general the characteristics of the empowerment process. These characteristics serve as a basis for the development of a measure of empowerment. A number of instruments exist that attempt to measure empowerment, like Diabetes Empowerment Scale [9], Patient Activation Measure [19], and Consumer Constructed Scale in mental health services [10]. However, no single measure exists to identify the level of empowerment in a general patient population.

6. Conclusion: Empowerment and the "power" of the payer

Medicine is now challenged on many fronts: the growing complexities of care, aging populations, shortages in medical specialties, a movement towards chronic conditions and payers that are increasingly concerned with evidence concerning both effectiveness and cost. Faced with these many challenges, and the near impossibilities of meeting the needs of all stakeholders, it is clear why empowerment is being discussed. While much of the reviewed literature pertains to North America, the issues that have emerged there are increasingly relevant to Europe. This is especially true as financing methods like diagnosis-related groups and managed/coordinated care are actively adopted in Europe while governments/payers utilize technology assessment to control the health care system [20].

Patient empowerment has increasingly dominated the literature. Therefore, is of particular importance to discuss the implications for European health care policy, as many European countries have attempted to empower patients in order to unburden the health care system. However, patients in some countries, especially in Eastern and Central Europe, continue to remain relatively unempowered [26,27].

The growing literature on patient empowerment is particularly relevant to the patient rights movements in Europe. In recent years, patients have become more vocal in health care policy development in Europe. Some countries, like Germany and the UK, have included patients on important decision making bodies in the health care systems [22,26]. Unfortunately, sometimes these approaches focus on "professional" patients, and often lead to the politicization of the patient's viewpoint rather than promoting patient centred care [20]. European health care policy makers need to develop clearer, evidence based mechanisms to comprehend the needs and views of all patients in the system [28]. The literature demonstrates that this can be facilitated through grass-roots movements that promote better doctor-patient communication [2] or by the scientific study of patient preferences, values and patient report outcomes [20,26,27].

It is perhaps noteworthy that of all the articles in the medical literature on empowerment, not one took the perspective of the payer. Certainly, in recent years the power of the payer has increased in most countries; this is especially true in European countries who have adopted health technology assess and other mechanism to regulate access to medicines [23]. Here, however, there have been different paths taken, which have significant impact on all stakeholders. For example, countries like Switzerland and The Netherlands have reformed their insurance systems to empower patients through choice and to promote managed competition among providers. Other countries like the UK have taken a much more centralist, and potentially paternalistic, approach, using technology assessment (and particularly cost-effectiveness analysis) as a means of managing scarce resources [20,24]. While such a system disempowers patients and providers alike, its proponents claim that it is a more efficient and equitable method of managing scarce resources. The effects of these systems on empowerment and outcomes are certainly far from proven and are complicated by rhetoric and politics [29,30]. A more scientific approach to issues of empowerment, rather than one built on advocacy, will certainly lead to a better understanding of its role in medicine and its effects on outcomes.

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