

Making time for patient centred care

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Senior medical officer workforce shortages are an underlying barrier to achieving genuine patient centred care in district health boards.

To succeed, a patient centred approach must also address the staff experience, as staff's ability and inclination to effectively care for patients is unquestionably compromised if they do not feel cared for themselves.¹

If health care organisations want to become patient centred, they must create and nurture an environment in which their most important asset—their workforce—is valued and treated with the same level of dignity and respect that the organisation expects its employees to provide to patients and families.²

High quality patient centred care in New Zealand requires commitment across the whole spectrum of the health system, from the clinics and wards to the boardrooms and the Beehive. Being truly patient centred, where patients and their families are able to engage as effective partners at every level, is a continuous path rather than a destination. Developing and sustaining a patient centred culture across the whole systems requires adaptability and flexibility to meet the needs and expectations of patients, families and staff—needs that will inevitably evolve over time.³

Discrete patient centred care programmes, on their own, may address specific objectives but they will fall short of cultivating an authentically patient centred organisation. Patient centredness is not a check-list, a dashboard or an action plan. The literature describes it more as 'a cultural transformation'. A culture of patient centred care is characterised by the core values and attitudes behind the implementation of such programmes. It is about engaging the hearts and minds of the entire organisation's workforce, not least senior doctors, whose interactions with patients and their families lie at the heart of patient centred care.⁴

It is critical, therefore, for health service management to demonstrate a strong and long-term commitment to ensuring the workplace environment is conducive to achieving genuine patient centred care, recognising also the broad consensus in the literature that patient centred care and clinician care are two sides of the same coin. Poor work environments contribute to stress and burnout, staff turnover and medical errors; positive work environments promote high quality care and cost efficiency, and a more stable workforce.⁵

Many countries are facing the challenges of creating and maintaining good quality work environments in rapidly changing health systems that are increasingly strained due to funding constraints and inadequate health workforces. New Zealand is no exception.



Given the complexity of work environment issues, policies to achieve high quality working conditions need to be multidimensional and inclusive. Because effective solutions are context-related, priority has to be given to improving conditions at the 'front line' of service delivery, supported by management, which in turn requires the support of government policy and resources.⁶

In New Zealand the immediate task is to address specialist workforce shortages. New Zealand faces a steeper challenge than most other countries in the Organisation of Economic Cooperation and Development (OECD), where it ranks poorly on the number of specialists per population.⁷

Addressing entrenched specialist shortages

Long-term specialist shortages have been acknowledged by Health Workforce New Zealand as impacting on the 'workloads, wellbeing and productivity of DHB-employed senior doctors'.⁸ However, while the DHB specialist workforce has been growing, the net growth rate (approximately 175 on average over the past five years)⁹ is well short of what is needed to both address long-standing shortages and meet increasing health needs of a growing and ageing population.

To achieve parity with Australia's projected specialist workforce per population by 2021, for example (a modest target given Australia's figures are below the OECD average), DHBs require an estimated net growth of 300 specialists per year – about 125 specialists more than the current growth rate.

The effects of continuing shortages on the health and wellbeing of SMOs is well documented in two recent national surveys of SMOs which indicated significant prevalence of burnout and high levels of 'presenteeism'.^{10 11}

Addressing shortages as a top priority is needed not only to improve the health, wellbeing and morale of staff, recognising patient centred care requires the nurturing of staff as well as patients, but also to establish sufficient workforce capacity to deliver patient centred care, recognising patient centred care requires specialists to find more time to engage with patients and families. Specialists also need more time for all the activities that contribute to good patient centred care, including multidisciplinary teamwork, delivering better integrated care, distributive leadership and ongoing skills training and education, on top of increasing clinical workloads.¹²

Increasing the specialist workforce capacity of course depends on improving retention and recruitment. While New Zealand already relies heavily on international medical graduates (IMGs), with IMGs comprising 43% of the specialist workforce, building workforce capacity will require a continuing influx of IMGs for the foreseeable future. However, Medical Council data shows they have poorer retention rates than New Zealand trained doctors.

Given the importance of retaining IMGs, there is surprisingly little research available to guide policy responses. What is available suggests key issues include remuneration and barriers for partners and family to settle in New Zealand. That the demand for doctors is becoming increasingly competitive internationally should add further impetus to efforts to create more attractive work environments in our health services, including more welcoming approaches to doctors' families.^{13 14}

Addressing specialist workforce shortages is a prerequisite for addressing other 'quality of workplace' issues discussed below.

Reducing stress and improving work-life balance

Improving retention among older specialists is becoming more critical as many are nearing the traditional retirement age, raising concerns that this will exacerbate existing shortages. Strategies identified for improving retention include intervention to reduce stress, changing work roles, introducing more part-time and job-share positions and more flexibility in work hours.¹⁵

The growing number of women in the workforce, here and internationally, is adding to the challenges posed by an aging specialist workforce. Medical Council and Census data show women tend to work fewer hours than men. In 2014, women comprised 31% of the specialist workforce, compared with 19% in 2000.¹⁶ As this trend continues, the projected specialist headcounts required to ensure a viable and secure workforce will need to be adjusted upwards to achieve the same number of full-time equivalents.

In addition, a growing desire for a better work-life balance generally is likely to have a similar impact on workforce supply over the next decade. One Australian survey indicated 81% of hospital doctors want greater access to flexible working arrangements to allow them to spend more time with family and friends, or continue further formal training. The work-life balance factor is now a common draw-card in advertisements for medical positions.^{17 18}

Promoting safe and healthy workplaces

An extensive and growing international body of evidence shows fatigue in doctors – found to be highly prevalent in New Zealand DHBs¹⁹ – contributes to reduced wellbeing, reduced quality of care and increased errors and accidents.

In response, the Australian Medical Association (AMA), with the support of the Federal Government, has produced a *National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors*, which applies to all hospital employers and salaried hospital doctors. It was prepared in recognition of the responsibilities of employers and employees under occupational health and safety (OH&S) legislation, which is similar to New Zealand’s occupational health law.

The code is one part of a broader education and awareness programme to change a culture that supports long working hours and unhealthy work patterns.

The scope of the code is limited to hazards related to shiftwork and extended working hours and the effect on the health and safety of individual doctors and impacts on patient care. Because the level of fatigue and the consequent effect on safety and work performance is complicated and is the product of a range of factors, the code does not contain absolute, enforceable limits on single elements such as the maximum length of a safe shift or the break required between episodes of work. Instead, the code contains a *Risk Assessment Guide* and a *Risk Assessment Checklist* to help identify fatigue factors and assess the risk level of an individual’s working hours. It then provides the tools to reduce the identified risk levels. The model is essentially: hazard identification, risk assessment and risk control.

This is a voluntary code. It does not have evidentiary status but has legal status like all other guidance in that it contributes to ‘the state of knowledge’ about a particular hazard or risk and the ways of mitigating that hazard or risk. It provides recommendations for duty holders to consider in meeting their legal obligations.

Also, to be effective a broader strategy is needed, including – in the AMA’s words – “an education and awareness programme to change the current individual and organisational beliefs and culture that support working hours and patterns that would be considered unacceptable in most other industry sectors”.

The recent ASMS survey on the prevalence and level of fatigue in senior doctors in New Zealand points to an urgent need for an effective policy response from DHB management, which the ASMS is currently pursuing.

Continuing professional development

Patient centred organisations focus on increasing their staff skills to support patient centred care delivery. Strategies to achieve this include continuing professional development in communication skills, and holding education sessions for healthcare professionals where patients and families share their experience of care.²⁰

While communication skills training improves doctor-patient communication, the improved behaviour can lapse over time, so it is important to practise new skills with regular feedback on the acquired behaviour.²¹ Furthermore, the rising complexity of care trajectories, due to the growing numbers of chronically ill patients, further increases the communication demands facing clinicians, requiring increasingly sophisticated kinds of communication amidst complexity.²²

Research findings demonstrate that effective communication heals, and that sub-standard communication can adversely affect patient care. Paying close attention to what defines effective patient-clinician communication in a complex and constantly changing environment is therefore critical to the quality and safety of contemporary health care. It is an important part of specialists' continuing professional development (CPD), which the Medical Council of New Zealand (MCNZ) requires of all practising doctors in order to be issued with a practising certificate each year in line with the requirements of the Health Practitioners Competence Assurance Act (HPCA).

Specialists are also urged to use their CPD to develop and maintain cultural competency.²³ Under the HPCA, the MCNZ requires doctors to show they are culturally competent by demonstrating the appropriate attitudes, awareness, knowledge and skills towards their patients irrespective of the patients' cultural background. Cultural competency includes not only ethnicity but is also matters "...related to gender, spiritual beliefs, sexual orientation, lifestyle, beliefs, age, social status or perceived economic worth."²⁴

Maori and Pacifica health status indicators alone underscore the importance of cultural competence. This is emphasised further by New Zealand's heavy reliance on IMGs.

A Memorandum of Understanding between the MCNZ and DHBs includes, among other matters, the requirement that DHBs shall:

- Provide an environment which supports learning and development and which allows DHB-employed doctors to fulfil their recertification and accreditation requirements.
- Ensure collegial relationship arrangements are in place and that doctors have access to continuing professional development resources.²⁵

Despite this MOU, emerging evidence that many specialists are unable to access appropriate levels of non-clinical time to undertake activities such as CPD further indicates the urgent need to address specialist shortages.²⁶

Promoting clinical leadership

Effective clinical leadership is another key factor in achieving patient centred care.^{27 28 29} There are a number of reasons for this.

First, as has been found in Britain's National Health Service (NHS), the command and control, 'pace-setting' leadership style – otherwise known as 'managerialism' – is incapable of accommodating the complexities of a more participative, supportive environment that is required for patient centred care.^{30 31}

The need for service-specific knowledge – understanding how clinical services work and what is required to provide high-quality care – means clinicians need to be among the people leading the change.

The practicalities of improving health care require activity right across the system, involving the whole spectrum of healthcare professionals. In exceptional organisations leadership for improvement involves reforming the system through a sustained effort, often over many years. This effort is designed to create the ways of working, people development, culture, systems and environment that are the conditions for promoting improvement.³²

Patient and staff experiences are inextricably intertwined. Consequently, to approach patient-centred care as exclusively about the patient and family is to overlook a critical piece of the puzzle. The insights of staff, at the clinical team level, provide critical intelligence for how to foster an environment that is nurturing not only for patients and families but also for health care professionals.^{33 34}

Involving senior doctors directly in the design and implementation of patient centred processes is an important way to achieve engagement, improves the efficiency and quality of services, increases patient and staff satisfaction, improves safety and reduces staff turnover.^{35 36}

Studies on the effects of engagement have consistently shown that improvement in healthcare is a cultural phenomenon that relies upon the contribution of staff who are not only individually motivated but are also provided with the appropriate time and opportunities to apply their skills, knowledge, and experience.

A 'medical engagement scale' developed for the NHS to assess the effects of management and organisational systems on doctors' engagement, has three aspects: working in an open culture; having purpose and direction; and feeling valued and empowered. Data from almost 30 hospitals using the scale revealed a strong association between medical engagement and performance measured by the Care Quality Commission.³⁷

A related study by the NHS Institute and the Academy of Royal Medical Colleges identified the lessons from seven NHS organisations with the highest levels of medical engagement. All acknowledged it took time and was often challenging, and disengagement could be sudden and precipitous. But they highlighted consistent benefits such as successful initiatives, innovation, staff satisfaction and retention, improved organisational performance and better patient outcomes. The organisations emphasised that engagement should be persistent and reach the entire medical workforce, not just those at the top.³⁸

The benefits of engagement are mirrored in numerous studies on clinical leadership in general. There is now a strong consensus internationally that collective or distributed clinical leadership is the required model to meet the challenges facing health care systems around the world.

Support from management and government

The New Zealand Government has acknowledged the importance of engagement, broadly, and clinical leadership specifically through several policy documents and, until recently, implementing clinical leadership was signalled as a high priority in the Minister of Health's annual 'Letter of Expectations' to DHBs.

Surveys of senior doctors about the extent to which clinical leadership is being implemented by DHBs, however, indicated a major fault-line between policy intent and policy in practice.³⁹

Commitment from management and, in turn, government from the outset is critical for any major new policy to find traction. Staff in many hospitals have become accustomed to, and often disillusioned by, 'flavour of the month' initiatives that are launched with much fanfare only to disappear when results do not materialise as expected.⁴⁰

The omission of any mention of clinical leadership in the Minister's most recent 'Letter of Expectations', and its omission from the recently updated New Zealand Health Strategy, suggests the government's position on clinical leadership has changed from being a 'fundamental driver of better health services' to a theoretical 'nice to have'. Unless concerted commitment is shown by DHB management and the government to distributed clinical leadership, which is a critical component of patient centred care, the latter is in danger of also being relegated to a 'nice to have'.

It may be that DHB management's poor record in implementing distributed clinical leadership is due at least in part to continuing financial constraint forcing a focus on short-term decision making, but broader government health policy priorities may also be cutting across longer term strategic policies such as clinical leadership and patient centred care.

A study on leadership styles in the NHS identifies the dominant approach as typified by laying down demanding targets, leading from the front, often being reluctant to delegate, and collaborating little – and is the consequence of the health service focusing on process targets, with recognition and reward dependent on meeting them.^{41 42} Such an approach will be familiar to many working in New Zealand's public health system.

Targets in the NHS, as in New Zealand, may have helped to increase elective surgery volumes (though not sufficient to meet evident growing unmet need) and bring about faster treatment in emergency departments. However, they have done so at the cost of a dominating top-down leadership approach to the exclusion of other leadership styles, such as 'affiliative' – creating trust and harmony – or 'coaching'.⁴³

As a former senior government health official has commented: "...ministers from successive governments have become besotted with targets – technology has enabled ministerial insight into the very heart of health services, and offers the opportunity to micro-manage these interactions like never before. This is truly transforming the system, but not in the way you might imagine. Technology, and its enabling of the use of precise targets, has narrowed the decision space of district health boards to the point that they are losing a sense of oversight of the sector at the local level, losing their focus on equity, and are redefining themselves as, in the words of Capital and Coast DHB, 'An organisation configured to achieve health targets.'⁴⁴

If patient centred care, as the literature indicates, requires a cultural transformation across health care organisations, the evidence also suggests government policies and priorities need to be better aligned to support such change instead of impeding it.

Supporting patients to become true partners in care, and a particular focus on engaging Maori patients and whanau, will be discussed in a future publication.

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