

Why is patient centred care so important?

By Lyndon Keene, Director of Policy and Research, lk@asms.nz

There is good evidence that patient centred approaches to health care improve safety, quality and cost effectiveness, as well as levels of patient and staff satisfaction. This is the second in a series of discussion papers about patient centred care.

If patient centred care is ultimately determined by the quality of the interaction between patient and doctor, the first question to address is how good that interaction is.

According to recent patient experience surveys overseen by the Health Quality & Safety Commission, nearly 9 out of 10 New Zealand public hospital patients feel staff always treated them with dignity and respect while they were in hospital. Less impressive, however, are the survey responses concerning the information patients received from clinicians about their treatment and condition, and the extent of involvement in decisions about their care and treatment.^{1 2}

For example, just 72% of respondents could give a definite 'yes' to the question: 'Was your condition explained to you in a way that you could understand?' Only two-thirds of patients felt they were involved as much as they wanted to be in care and treatment decisions, and only half said they were given a full explanation about medication side-effects to watch for when they went home. Such survey results are not unusual in the health systems of other comparable countries.^{3 4}

Internationally, end-of-life care features in many discussions about patient centred care. New Zealand's demographic trends point to a continuing rise in the number of people dying each year, many with chronic, complex needs and often complex treatment options. Patients who are in the last year of their lives may receive input from a great number of medical and non-medical health professionals in a range of care settings and are likely to present repeatedly. Many patients, such as those with advanced dementia, may no longer be able to express their wishes. Ensuring that these patients (and, where appropriate, their families) are well informed and involved in deciding treatment decisions can be challenging.⁵

According to an international 'Quality of Death Index' devised by The Economist Intelligence Unit (EIU) in the United Kingdom (UK), New Zealand does well on the overall quality of its palliative care, ranking third out of 80 countries (behind the UK and Australia).^{6 7} However, the EIU adds the caveat that even in those countries that score well there is evidence of service failings. It cites a UK ombudsman's investigation into complaints about end-of-life care, which found regular occurrences of poor symptom control, poor



communication and planning, not responding to the needs of the dying, inadequate out-of-hours services and delays in diagnosis and referrals for treatment.⁸

Significant shortcomings have also been reported in New Zealand. While the need for palliative care will increase considerably in the coming decade, Ministry of Health projections indicate the number of palliative medicine specialists will fall.⁹ On current workforce trends New Zealand is projected to have less than 70% of the palliative specialists needed in the next 5 to 10 years, at a time when they are becoming in increasing demand internationally.^{10 11}

A Royal Australasian College of Physicians (RACP) survey of Fellows' and trainees' attitudes, knowledge and practice of end-of-life care and Advance Care Planning (ACP) found indications that many patients nearing the end of life are provided with treatment that is inappropriate or against their wishes. About a third of respondents who care daily for patients who may die in the next 12 months observed treatment being given that was inconsistent with the patient's wishes at least once a week. Of all respondents, 37% indicated they had observed treatment with little chance of significant benefit being provided to patients at least once per week. This was observed by 44% of trainees. Only 17% of respondents to the RACP's survey agreed that *most of the time doctors know the patient's preference regarding end of life care*.¹²

The evidence for patient centred care

Shortcomings in doctor-patient interaction have been reported in numerous studies internationally, yet there is growing evidence of the many benefits when that interaction is good: the quality and safety of health care rises, costs decrease, and doctor and patient satisfaction increase. Research findings demonstrate that effective communication heals, and that sub-standard communication may have negative health effects.^{13 14 15 16}

For example:

- Patients reporting good communication with their doctor are more likely to be satisfied with their care, and especially to share pertinent information for accurate diagnosis of their problems, follow advice, and adhere to the prescribed treatment.^{17 18 19 20 21 22}
- Patients' agreement with the doctor about the nature of the treatment and need for follow-up is strongly associated with their recovery.^{23 24}
- Good patient-doctor interaction can improve patients' health outcomes.^{25 26 27}
- Good patient-doctor interaction can improve patient safety and reduce medical error rates.^{28 29 30}
- Studies have shown good doctor-patient communication improves the control patients feel over their care and treatment, which in turn can have a positive impact on their ability to manage pain, recovery from illness, and daily functioning.^{31 32 33}
- Good patient-doctor interaction can improve patients' psychological adjustments and mental health.^{34 35 36 37 38}

- Some studies have observed good patient-doctor communication can shorten the length of hospital stay and therefore reduce the cost of individual medical visits and result in fewer referrals.³⁹

The quality of patient-doctor communication is also critical in supporting people with long-term conditions to develop the knowledge, skills and confidence they need to better manage their own health and care. As the population ages, increasing numbers of people are living with long-term conditions which account for a significant portion of total health services. It is estimated that two out of three New Zealand adults have at least one long-term condition and it's the leading cause of preventable death.^{40 41}

Patients perceive that self-management of their condition can be facilitated when clinicians and patients view health care as a shared responsibility, underpinned by clinicians as experts in the disease and patients as experts in living with it.⁴²

Self-management can save money as well as being clinically effective.⁴³ Currently, there are two main models of self-management support: group-based patient education programmes and clinician-patient collaboration within routine consultations.^{44 45} This second model should improve access to self-management support, be deliverable where capacity is not available within teams for lengthy group programmes, and benefit patients who would not attend a group. There is evidence that patients want assistance with managing their health conditions. For example, a UK survey with more than 1200 rheumatology patients with inflammatory arthritis found that 82% wanted help with managing the impact of pain and fatigue and 57% to manage emotions, and 66% reported that they would access a self-management support clinic.^{46 47}

Supporting patients with long-term conditions to manage their health and care can improve clinical outcomes. When people are more involved, they are less likely to use emergency hospital services. They are also more likely to stick to their treatment plans and take their medicine correctly.^{48 49}

Patients who have the opportunity and support to decide their care and treatment in partnership with health professionals are more satisfied with their care,⁵⁰ are more likely to choose treatments based on their values and preferences rather than those of their clinician,⁵¹ and tend to choose less invasive and costly treatments.⁵²

Individuals who have more knowledge, skills and confidence to manage their health and health care are more likely to behave in ways that help them be healthy, and to have better health outcomes.⁵³

If a patient centred care approach is to succeed, however, it must address staff needs. The ability of health staff to care effectively for patients is compromised if they do not feel cared for themselves. Once the patient centred care approach is firmly established, a positive cycle emerges where increasing patient satisfaction also increases employee satisfaction, and this, in turn, improves employee retention rates and the ability to continue practising patient centred care. As patient engagement increases, staff performance and morale see a corresponding increase.⁵⁴



References:

- ¹ HQSCNZ. A Window on the Quality of New Zealand's Health Care, July 2015
- ² HQSCNZ. National patient survey results: Results for patients treated in November 2015. Updated 29 February 2016. [http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/2459/#\[DHBresults](http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/2459/#[DHBresults)
- ³ HQSCNZ. A Window on the Quality of New Zealand's Health Care, July 2015
- ⁴ K Davis, S Stremikis, et al. *Mirror, Mirror on the Wall: How the performance of the US health care system compares internationally*, Commonwealth Fund, June 2014.
- ⁵ RACP. Submission to the Victorian Government's Discussion Paper: "Greater say for Victorians - Improving end of life care", 2015.
- ⁶ The Economist Intelligence Unit. The 205 Quality of Death Index: Ranking Palliative Care Across the World, commissioned by the Lien Foundation, September 2015
- ⁷ The Economist Intelligence Unit. The 205 Quality of Death Index: Country Profiles, commissioned by the Lien Foundation, September 2015.
- ⁸ Parliamentary and Health Service Ombudsman, *Dying without dignity*, May 2015. Available at http://www.ombudsman.org.uk/_data/assets/pdf_file/0019/32167/Dying_without_dignity_report.pdf
- ⁹ Ministry of Health. Medical Specialty Workforce Model: Palliative Medicine, supplied by the Ministry of Health, 2016.
- ¹⁰ A O'Callaghan, J Adler. *New Zealand Palliative Medicine SMO workforce projections and training capacity*, Health Workforce New Zealand, August 2014.
- ¹¹ A O'Callaghan, J Adler. "Advance care planning for a palliative medicine workforce crisis," *The Specialist*, ASMS, December 2014.
- ¹² RACP (2015).
- ¹³ R Iedema, M Manidis. *Patient-Clinician Communication: An Overview of Relevant Research and Policy Literatures*. Australian Commission on Safety and Quality in Health Care and UTS Centre for Health Communication, Sydney 2013.
- ¹⁴ Australian Commission on Safety and Quality in Health Care, *Patient centred care: Improving quality and safety through partnerships with patients and consumers*, ACSQHC, Sydney 2011.
- ¹⁵ P Charmel, S Frampton. "Building the business case for patient centred care," *Healthcare Financial Management*, March 2008; 80-85.
- ¹⁶ A Boon. *Excellence through family and patient centred care: Literature Review*, Bay of Plenty DHB, 2012.
- ¹⁷ J Fong Ha, N Longnecker. "Doctor-patient communication: A review," *The Ochsner Journal*, 2010 Spring; 10(1): 38-43.
- ¹⁸ J Henrdon, K Pollick. "Continuing concerns, new challenges, and next steps in physician-patient communication," *J Bone Joint Surg Am*. 2002;84-A(2):309-315.
- ¹⁹ N Arora. "Interacting with cancer patients: the significance of physicians' communication behaviour," *Soc Sci Med*. 2003;57((5)):791-806.

²⁰ JR Tongue J, HR Epps, LL Forese. "Communication skills for patient centred care: research-based, easily learned techniques for medical interviews that benefit orthopaedic surgeons and their patients," *J Bone Joint Surg Am.* 2005;87:652–658

²¹ CH Kindler, L Szirt, D Sommer, et al. "A quantitative analysis of anaesthetist-patient communication during the pre-operative visit," *Anaesthesia.* 2005;60((1)):53–59.

²² M O'Keefe. "Should parents assess the interpersonal skills of doctors who treat their children? A literature review," *J Paediatr Child Health.* 2001;37((6)):531–538.

²³ A Fors, I Ekman, C Taft, et al. "Person centred care after acute coronary syndrome, from hospital to primary care — A randomised controlled trial," *International Journal of Cardiology,* 6 May 2015; Vol 187, 693-699.

²⁴ M Stewart, JB Brown, A Donner, et al. "The impact of patient centred care on outcomes. *J Fam Pract.* 2000; 49((9)):796–804.

²⁵ RL Street, G Makoul, NK Arora, RM Epstein. "How does communication heal? Pathways linking clinician-patient communication to health outcomes." *Patient Education and Counselling,* 2009; 74:295-301

²⁶ NK Arora. "Interacting with cancer patients: the significance of physicians' communication behaviour," *Social Science and Medicine,* Volume 57, Issue 5, September 2003, Pages 791–80.

²⁷ JK Rao, LA Anderson, TS Inui, RM Frankel. "Communication interventions make a difference in conversations between physicians and patients: A systematic review of the evidence," *Medical Care,* vol. 45, 2007; no. 4, pp. 340-349.

²⁸ T Mitschang. *Bridging the Patient-Doctor Communication Gap,* IG Living, Oct-Nov 2013.

²⁹ A Coulter, J Ellins. *Patient-focused interventions: A review of the evidence.* London: Picker Institute Europe/ Health Foundation, 2006.

³⁰ Y Longtin, H Sax, LL Leape, SE Sheridan, et al. "Patient Participation: Current Knowledge and Applicability to Patient Safety," *Mayo Clinic Proceedings* 2010; 85(1):53-62.

³¹ C Durif, P Roux, H Rousset. "Medication and the doctor-patient relationship: a qualitative study with patients suffering from fibromyalgia," *Health Expectations,* 2014;18, pp.2584–2594.

³² C Doyle, L Lennox, D Bell. "A systematic review of evidence on the links between patient experience and clinical safety and effectiveness," *BMJ Open* 2013;3:e001570.

³³ RM Epstein, K Fiscella, CS Lesser, KC Stange. "Why the Nation Needs a Policy Push on Patient-Centred Health Care," *Health Affairs,* 2010;29(8):1489–95.

³⁴ J Henrdon, K Pollick. "Continuing concerns, new challenges, and next steps in physician-patient communication," *J Bone Joint Surg Am.* 2002; 84-A((2)):309–315.

³⁵ M Stewart, et al (2000).

³⁶ DL Roter, JA Hall, Y Aoki. "Physician gender effects in medical communication: a meta-analytic review," *JAMA.* 2002;288((6)):756–764.

³⁷ P Maguire, C Pitceathly. "Key communication skills and how to acquire them," *BMJ.* 2002;325(7366):697-700.

³⁸ NK Aror (2003).

³⁹ J Fong Ha, N Longnecker (2010).

-
- ⁴⁰ The Health Foundation. *Evidence: Helping People Help Themselves: A review of the evidence considering whether it is worthwhile to support self-management*, May 2011.
- ⁴¹ Hon J Coleman. "Patient feedback improves the management of long-term conditions," Minister of Health's media statement, 3 May 2016.
- ⁴² E Dures, S Hewlett, N Ambler, et al. "A qualitative study of patients' perspectives on collaboration to support self-management in routine rheumatology consultations," *BMC Musculoskelet Disord*. 2016; 17: 129. Published online 2016 Mar 15. doi: <http://bmcmusculoskeletdisord.biomedcentral.com/articles/10.1186/s12891-016-0984-0>
- ⁴³ E Dures, S Hewlett. "Cognitive-behavioural approaches to self-management in rheumatic disease," *Nat Rev Rheumatol*. 2012;8:553–9. doi: 10.1038/nrrheum.2012.108.
- ⁴⁴ D De Silva. *Helping people help themselves*. London: The Health Foundation, May 2011. <http://www.health.org.uk/publication/evidence-helping-people-help-themselves>
- ⁴⁵ J Cramm, A Nieboer. "A longitudinal study to identify the influence of quality of chronic care delivery on productive interactions between patients and (teams of) healthcare professionals within disease management programmes," *Brit Med J Open*. 2014;4.
- ⁴⁶ E Dures, C Almeida, J Caesley, A Peterson, et al. "Psychological support provision for adults with inflammatory arthritis in secondary care," *Musculoskeletal Care*. 2014;12:173–81. doi: 10.1002/msc.1071
- ⁴⁷ E Dures, et al (2016).
- ⁴⁸ D De Silva. *Helping people help themselves*. London: The Health Foundation, May 2011, p6. www.health.org.uk/publications/evidence-helping-people-help-themselves
- ⁴⁹ National Institute of Health and Care Excellence (NICE). *Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence*. NICE, 2009. <http://www.nice.org.uk/guidance/cg76>
- ⁵⁰ D De Silva. *Helping people share decision making*. London: The Health Foundation, July 2012, p.9. www.health.org.uk/publications/helping-people-share-decision-making
- ⁵¹ AM O'Connor, et al. "Modifying unwarranted variations in health care: shared decision making using patient decision aids," *Health Affairs*, web exclusive, 7 October 2004.
- ⁵² D De Silva D. *Helping people share decision making*, The Health Foundation, June 2012, p.12. www.health.org.uk/publications/evidence-helping-people-help-themselves
- ⁵³ J Hibbard, H Gilbert. *Supporting people to manage their health: An introduction to patient activation*. The King's Fund, 2014.
- ⁵⁴ The King's Fund. *Leadership and engagement for improvement in the NHS: Together we can*. London: The King's Fund, 2012.