

The time barrier

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Commonly identified barriers to delivering patient centred care include time constraints, workload, inadequate communication skills, poor patient health literacy, lack of leadership and, for some clinicians, an unwillingness to change. From the senior medical officer workforce perspective, a common factor, directly or indirectly, is time.

Time pressure on doctors

A Royal Australasian College of Physicians (RACP) survey of fellows' and trainees' attitudes, knowledge and practice concerning end-of-life care and discussions with patients about future health care options through Advance Care Planning processes found many patients nearing the end of life are provided with treatment that is inappropriate or against their wishes.¹

Of all respondents to the RACP survey, 34% had commenced an Advance Care Plan conversation with a patient in the past six months and 32% had not done so. The survey identified the following potential barriers to undertaking Advance Care Planning:

- time constraints (62%)
- insufficient relationship with patients (46%)
- health literacy of the patient or family (41%)
- lack of skills of the doctor (30%)
- discomfort in having end of life or Advance Care Planning conversations (26%)
- unavailability of appropriate place for discussions (20%)
- patients aren't interested (18%)
- language barrier (16%).

Most of these identified barriers are directly or indirectly related to the doctor's time – whether it is time to have the (sometimes many) conversations with the patient and family, especially if the patient has difficulty understanding the information, or whether it is time for the doctor to undertake skills training or obtain other support as needed.



The doctor's time factor arises frequently in the literature discussing barriers to patient centred care.^{2 3 4 5 6 7 8 9}

A systematic review of health professionals' perceptions of the barriers and facilitators to implementing shared decision-making (SDM) in clinical practice found the most often reported barrier to SDM is time constraints (18 of 28 studies).¹⁰ The review included the views of more than 2784 health professionals from 15 countries (most of them doctors).

An English survey of National Health Service (NHS) clinicians and managers seeking their views on the factors affecting the quality of patient care and the role of leadership in delivering improvements found 'time and/or resources' were considered the biggest obstacle to improving patient care.¹¹

An Australian study involving interviews with chronically ill patients and their (non-health professional) carers about their experiences with the health system found: "One of the most common challenges experienced by participants related to insufficient GP and specialist consultation time. Consultations concentrated on the immediate problem, leaving little time to discuss warning signs of emerging problems associated with the chronic illness..." Interviews with health care professionals in the same study reinforced patients' observations that poor communication was a major barrier to good health care. They linked this to patients' low levels of health literacy, but also saw limited time and human resources as 'significant barriers'. They observed that specialists "are often busy and lack sufficient time to provide thorough information." They also suggested that patients and carers sometimes hesitated to ask questions of doctors due to doctors' time constraints.¹²

Similar time pressures have been identified in New Zealand, which has fewer specialists per head of population than most other countries cited in the literature on patient centred care. Surveys of Heads of Department in two district health boards (DHBs) to ascertain the adequacy of current senior medical officer (SMO) staffing levels to meet local health needs indicate time pressures on SMOs are compromising the quality of care. Almost three-quarters of respondents at Hawke's Bay DHB and, based on preliminary results, around half of respondents from MidCentral DHB believed their staff had insufficient time to spend with patients and their families to provide good quality patient centred care.¹³

Time pressure on multidisciplinary teams

Time pressures not only affect patient-doctor communication but also communication between clinicians. While much of the literature on patient centred care focuses on patient-clinician interaction – and the actions of each individual clinician are critically important – achieving the patient centred care objectives usually requires well-coordinated teams of health care professionals working together with these goals in mind.¹⁴ Effective team performance can in turn have a positive impact on quality and patient safety. The safety literature emphasises the value of highly collaborative teams and links them to error reduction and effective performance in multiple settings.^{15 16}

Multidisciplinary meetings form the lynchpin of effective teamwork by providing a forum for interdisciplinary communication, decision-making and co-ordination of care. However, time pressures are often seen as a major barrier to organising regular team meetings.^{17 18 19}

An English study examining staff perceptions of team-working in the field of stroke care found: “Staff often raised concerns regarding team functioning to issues of time, and expressed concern at the need to balance patient contact time against team-working time. Multidisciplinary meetings for example were identified as an important decision-making forum, but staff expressed concern at the time taken up by them during a working week, and how they often were required to make choices between these and patient contact time, as illustrated in the following staff comments:²⁰

“To be honest I just see my bit and I don’t look at anybody else’s bit... which maybe I should...but I just don’t have the time.”

“We don’t generally go in for goal setting... cos we haven’t got time.”

“It can be frustrating because again that takes time out to be able to communicate to pass that knowledge on or be open to other people’s opinions, um... takes time out of what it is you are wanting to do, so if you’ve got your day planned and you’ve got six or seven sessions in and you want to see those patients... if you need to take the time to pass that knowledge on or gain more knowledge that obviously has an impingement on time.”

Staff concerns regarding the time taken up by team-working echo the findings of an earlier three-year study on the effectiveness of discharge planning and multidisciplinary teamwork, which found “a lack of time due to heavy work pressure... [as] the biggest barrier affecting inter-professional working and coordination of assessments.”²¹

When health care team members do not communicate effectively, patient care often suffers. Research conducted over 10 years to 2005 demonstrated that ineffective team communication was the root cause for nearly 66% of all medical errors during that period. Further, medical error vulnerability is increased when health care team members are under stress or are in high-task situations.²²

Staffing and workload demands were identified by doctors and nurses in Britain’s National Health Service as a key underlying cause for reported cases of deterioration of hospital patients which was not recognised or not acted upon and resulted in patient deaths.²³

A King’s Fund study found:

Clinical teams perform best when their leaders value and support staff, enable them to work as a team, ensure that the main focus is on patient care, and create time to care.²⁴

Time pressure on delivering integrated care

Beyond the multidisciplinary team, integration with other teams and other services is also fundamental to providing patient centred care. However, again, increased workloads and time are often identified by clinicians as factors affecting the delivery of integrated care.²⁵

Studies show that providing integrated care demands extra time from clinicians to communicate patient details with other service providers (eg, social worker and GP),²⁶ increased administrative duties²⁷ and a general increase in the volume of work.²⁸ Stress and fatigue have been identified as having an impact on staff,²⁹ and concerns about overloading staff are also evident.^{30 31} One study also indicated that integrated care models may necessitate increased staff responsibilities within the same role and salary level, which when coupled with a culture of longer working hours and a feeling of 'always being on duty' may not be received positively.³²

Time for leadership

Effective clinical leadership is another key factor in achieving patient centred care.^{33 34 35}

However, in 2010 a national survey of ASMS members on the application of clinical leadership in DHBs found a mere 20% of respondents believed they have enough time to engage in clinical leadership activities or development programmes.³⁶

Following the survey of ASMS members in 2010, two further surveys of members, conducted in 2013 and 2015, examined the performance of chief executives, senior managers, middle managers and human resource managers. Members were asked to assess their DHB's level of genuine commitment to distributive clinical leadership in its decision-making processes. In 2013, just 30% of respondents felt their DHB was genuinely committed to distributive clinical leadership, while 47% felt their DHB was not genuinely committed, and 23% didn't know.³⁷ By 2015 the findings were virtually unchanged.³⁸

The likelihood of clinical leadership (and by implication patient centred care) being afforded greater priority for senior DHB managers was set back when the Minister of Health, Hon Jonathan Coleman, omitted any reference to clinical leadership in his annual 'Letter of Expectations' to DHBs for 2016/17. It is the first time since the early 2000s that the Health Minister's letter does not highlight the importance of clinical leadership.

Strong commitment to patient centred care from senior health service management – and of course Government – is considered critical for its success. But while there is no available information to gauge this level of commitment, the evidence of senior management commitment to supporting distributive clinical leadership raises doubt about its commitment to genuine patient centred care.



Time for skills training and continuing education

Strategies to engage patients in health care highlight the importance of enabling clinical staff to undertake continuing professional development in communication skills and training in patient-centred values.^{39 40 41}

The RACP's report on its survey of fellows' and trainees' attitudes, knowledge and practice concerning end-of-life care and Advance Care Planning notes that although a majority of respondents had taken part in communication skills training, and many had completed training in ACP, they wanted to continue to improve their skills in these areas.

There is no readily available information to indicate the availability of such training programmes across the country, or how much they are supported by DHB management. However, findings of the surveys of Heads of Department in two DHBs to ascertain the adequacy of current SMO staffing levels (discussed above), show less than half the respondents at Hawke's Bay DHB believed their staff 'often' had access to the recommended level of non-clinical time (30% of hours worked), which includes time for ongoing professional development and continuing medical education. More than a quarter of respondents at Hawke's Bay DHB believed their staff 'never' or 'rarely' accessed the recommended level of non-clinical time. Preliminary results from MidCentral DHB suggest only about a quarter of respondents believed their staff 'often' had access to the recommended non-clinical time, while more than half believed their staff 'never' or 'rarely' had access.

Workforce capacity

To succeed, a patient centred care approach must address staff needs, including staff capacity, because the staff's ability to care effectively for patients is compromised if they do not feel cared for themselves.^{42 43} A study involving interviews and surveys with patients, managers and nursing and medical staff concluded: "Individual employee wellbeing is an antecedent, rather than a consequence, of patient care performance."⁴⁴

However, in New Zealand and overseas, health service staff morale has been hit by staff shortages and policies with a focus on budgets, throughputs, production, and targets which have been described as 'dehumanising'^{45 46} and 'industrialisation' of health care where the role of medicine is changing from "a craft concerned with the uniqueness of each encounter with an ill person, to a mass manufacturing industry preoccupied with the throughput of the sick."⁴⁷

The time pressures on doctors discussed in this paper are in part a reflection of entrenched specialist shortages in New Zealand, exacerbated by increasing health need, an aging workforce and a heavy dependence on international medical graduates (IMGs) which puts services in a vulnerable position because of the increasing international competition to attract specialists.^{48 49}

Shortages of medical specialists have been acknowledged by Health Workforce New Zealand (HWNZ):

The most important issue currently is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.⁵⁰

Partly as a consequence, burnout of doctors is commonplace.

The increasingly high levels of job burnout observed among physicians globally is set to continue as fewer resources and tighter budgets ratchet up the personal and professional pressure.⁵¹

The evidence suggests that burnout has major repercussions for patients and employers, including poorer perceived and real patient care along with higher staff turnover.^{52 53}

A survey of New Zealand hospital doctors published in 2004 found nearly 30% of respondents suffered psychological distress, with 10% classified as severe. Most frequent stressful situations reported were associated with work demands, commonly found in other studies.^{54 55}

A study involving 267 consultants from a wide range of specialties at Canterbury DHB in 2006/07 found one in five had symptoms of high burnout, with long work hours and low job satisfaction being key contributory factors. A quarter of the respondents reported working longer than 60 hours per week.⁵⁶

An ASMS survey of DHB-employed SMOs to ascertain levels of burnout found half of all who responded (50.1%) reported symptoms of burnout, and 42.1% of respondents attributed burnout to the workplace, as illustrated in the following comments from respondents:⁵⁷

“...the acuity of the patients in our service has increased without enough staff to treat these patients. Non-clinical time has disappeared in consequence. Burnout is happening on the other members of the team and the SMOs mop up. I’m not ready to retire but am seriously considering moving on.”

“...One also needs time to think about the more patients with more challenging conditions and how best to manage them, which seems to be given no value whatsoever. All the system seems to be interested in is how many patients can be booked per clinic and these other tasks appear to be invisible and constantly more is asked of us... It’s a quietly stress invoking situation constantly feelings like you’re racing against the clock to perform all these various duties in a clinic session.”

A further indication of a medical workforce under stress is demonstrated in a major ASMS study which found many DHB-employed SMOs routinely go to work when they are ill.⁵⁸ The main reasons for doing so include not wanting to let their patients down and not wanting to over-burden colleagues.

The next paper in this series discusses strategies for overcoming the barriers to patient centred care outlined here.

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