

# Patient Centred Care Literature Review

Health professionals do not deal with disease.  
They deal with people who are concerned about their health.

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## Executive summary

This literature review was undertaken by the Dandenong District Division of General Practice, to explore the concept of 'patient centred care' and its relevance to the Diabetes Cardiovascular Risk Management Program. A systematic search of published literature (from 2002-2007) was conducted using electronic data sources. Forty relevant references were reviewed and 25 included in the literature summary.

Being patient centred means health care providers taking into account the patient's desire for information and for sharing decision making. Patient centred care requires a thorough explanation of disease to patients and exploration of their feelings, beliefs and expectations. It is the interaction between the clinician and the patient, and the clinician's ability to use the patient's knowledge and experiences to guide the consultation.

Doctors can refine their skills in ways that allow them to better attend to the person of the patient. Often a request from the doctor to 'tell me about yourself' will suffice. Patient activation is an important component of patient centred interviewing, it enables the patient to take control within the consultation and promotes self management.

The development of patient centredness is linked to perceived limitations in the conventional way of practicing medicine, often labeled the biomedical model or doctor centred clinical style. In doctor centred consultations their medical skills and knowledge predominate. They maintain control by using closed questions and giving the patient directions. Conversely, patient centred interviews recognize patients' needs and preferences by encouraging them to voice ideas and collaborate in the consultation. A patient centred model of care requires a shift from the doctor being the dominant participant, to one in which power is shared with the patient. Patients want more control and information. They would prefer that doctors listened better and interacted more with them as persons.

Most doctors provide partially patient centred care—although little is really known about what goes on in consultations.

While research into patient centred care is limited, evidence does indicate positive outcomes such as an increase in patient satisfaction; engagement and task orientation; and doctor satisfaction. It also shows system efficiencies, such as fewer diagnostic tests and unnecessary referrals. More effective patient-doctor relations have been reported resulting from patient centred care.

Patient centredness is an important focus in care for people with long-term conditions. The key is to form a partnership with patients, allowing them to express their individual issues (problems, fears, frustrations) with having a chronic disease. Patients deserve to be partners in their own care, and it can be delivered more effectively and efficiently when they are involved. This is especially true for diabetes, which has a challenging self management regime. The majority of their care is their own

responsibility and they are in control of their choices. It has been shown that when patients take an active role in managing their diabetes, it can lead to: better diabetes care; more efficient practices; healthier patients; more satisfied patients and providers. Collaborative diabetes management, with a team approach and the patient as the key player helps to improve communication and shared decision-making, thus improving the likelihood of them succeeding in self care.

Self management education has been developed to enhance the ability of patients with chronic disease to participate in their health care. Self management programs are increasingly being adopted as a structural approach to patient centred care. Group education is enabling patients to confidently manage their chronic condition as well as effectively negotiate the health care system. Unfortunately, only a small percentage of patients are willing to attend group sessions.

A patient centred general practitioner is aware that the patient's beliefs, knowledge and feelings play a part in the consultation. The general practitioner tries to see the illness through the patient's eyes and understand the reason for the consultation and also the patient's expectations. Limited time during the consultation is often cited as a reason that some general practitioners cannot provide patient centred care. Utilising nurses and other members of the general practice team can overcome time constraints.

Characteristics of patient centredness have been applied to health systems, involving designing services in ways that respond to individuals' preferences, needs and values. For example patient centred practices that provide superb access to care, patient engagement in care, quality clinical information systems, care coordination, integrated care, and information about practices so that the patient to select a doctor or practice most likely to meet their needs.

Some patients lack the confidence or skills to participate in decision making and may not benefit from patient centred care.

Patient centred care can be difficult to implement when doctors are over worked and morale is low. Some clinicians will not see it as a priority as outcomes are less clearly related to immediate health gain. Doctors may feel uncomfortable if they are not trained to respond to the person, only to the disease encounter. Some doctors claim that there is insufficient time to learn more about the person. However, evidence indicates that patient centred interviews do not take longer than a regular consultation

The health systems will increasingly rely on patient centred care and the involvement of the patient—to adhere to treatment, make behavioural changes and to self manage. Especially as it is a cost-effective way to improve health outcomes for the growing number of patients with chronic conditions.

## A Introduction

The Dandenong District Division of General Practice's (DDDGP) Diabetes Cardiovascular Risk Management Program (DCRMP) is for people with type 2 diabetes who have or are at risk of developing cardiovascular disease. DCRMP services aim to be consumer focused or 'patient centred'. That is, patients need to be partners in their own care, ideally contributing to decisions about their care.

This literature review documents the concept of patient centred care, with reference to general practice and diabetes care. The review attempts to answer the following questions:

- What is patient centred care?
- What are the benefits of patient centred care?
- Do patients want it? Do doctors practice it?
- How does it relate to chronic disease management and diabetes care?

The findings of the literature review will be considered, to see if patient centredness principles and strategies could further improve the care provided by general practitioners and the other DCRMP service providers.

## B Method

A systematic search of published literature was conducted between 2002 and 2007. Electronic data sources were used including Medline, Psychinfo, CINAHL and OVID. Google Scholar, the Cochrane library and other websites were also searched. Combinations of the following terms were used:

- Patient centred terms – patient centred care; patient centred(ness); person centred care; consumer centred care; physician patient relationship; doctor patient relationship; communication; consumer participation; patient involvement; consumer focused; empowerment; and self management.
- Chronic disease terms - chronic disease; diabetes; and diabetes mellitus.

## C Findings

The searches identified more than 40 relevant references. These were obtained and reviewed, 25 were included in the literature summary (see references). Seventy per cent of the literature was from peer-reviewed sources and thirty per cent were reports by reputable institutions, such as leading chronic disease agencies. The findings are described in the following sections:

- 1 Patient centred care
- 2 Other styles care
- 3 Patients' choice
- 4 Doctors' actions
- 5 Benefits of patient centred care
- 6 Chronic disease and patient centred care
- 7 Diabetes and patient centred care
- 8 Self management and patient centred care
- 9 General practice and patient centred care
- 10 Patient centred health care
- 11 Barriers

Fifteen references were not included and are listed in the bibliography.

# 1 Patient centred care

Being patient centred means health care providers taking into account the patient's desire for **information** and for sharing **decision making** (Stewart, 2001). This type of care requires a thorough explanation of disease to patients and exploration of their feelings, beliefs and expectations (Bauman, Fardy, Harris, 2003). Patient centred is sometimes described for what it is not: not technology centred; not doctor centred; not hospital centred; and disease centred (Stewart, 2001).

Elements fundamental to patient centred care are:

- Respect for the individual's values, expressed needs and preferences.
- Choice – patients have the right and responsibility to participate in health care decisions including treatment and management.
- Access to services required by the person's medical condition, including preventive care.
- Support – acknowledging and addressing the person's emotional and social needs. This means involving the person's family and friends (as the patient desires) and considering educational, cultural and personal factors affecting the person's ability to manage their condition.
- Education and information that is accurate, relevant and answers the person's concerns (National Asthma Council Australia, 2007).

Within the clinical consultation, patient centred care is the interaction between the clinician and the patient. It refers to the clinician's behavioural skills to customize care to the specific needs and circumstances of each individual, that is, to modify care to respond to the person, not the person to the care (National Diabetes Education Program, 2007). It encourages clinicians to think about ways of integrating patients' perceptions into consultations (Kinmonth, 1998). It involves seeking and accepting the patient's ideas, giving recognition and encouragement, treatment recognition and decision making in response to the individual patient's perspective (Prueksaritanond et al, 2004). The focus of the patient centred consultation is on the partnership between patients, families and providers (National Diabetes Education Program, 2007), with acknowledgement of patient's treatment and life goals (National Asthma Council Australia, 2007).

Other explanations of patient centred care are described in figure 1.

### Figure 1 Explanation of patient centred care

Balint (1969) describes patient centred medicine as 'understanding the patient as a unique human being', while for Byrne and Long (1976) it represents a style of consulting where the doctor uses the patient's knowledge and experiences to guide the interaction. McWhinney (1989) describes the patient centred approach as one where 'the physician tries to enter the patient's world to see the illness through the patient's eyes'. Giving information to patients and involving them in decision making have also been highlighted. For Laine and Davidoff (1996) patient centred care is 'closely congruent with, and responsive to patients' wants, needs and preferences'. The most comprehensive description is provided by Stewart, Brown, Weston, McWhinney, McWilliam and Freeman (1995) whose model of patient centred clinical method identifies six interconnecting components:

1. Exploring both the disease and illness experience
2. Understanding the whole person
3. Finding common ground regarding management
4. Incorporating prevention and health promotion
5. Enhancing the doctor-patient relationship
6. Being realistic about personal limitations and issues such as the availability of time and resources.

Source: Mead and Bower, 2000

Many variables potentially influence a doctor's propensity to be patient centred (Mead and Bower, 2000), (see attachment 2) including providers ability to learn about preferences from the patient's perspective (Davis et al, 2005). What this means for the provider is that they need to understand the patient's personal model. The provider needs to understand what the patient thinks about his diabetes, how using insulin fits into his lifestyle, what quality of life elements he especially values, how having diabetes makes him feel. Angry? Fearful? Embarrassed? Emotions and cognitions can compromise care, for example, patients who are angry with the care they are receiving or who are fed up with perceived criticisms of their self management fail to attend clinical appointments because they perceive them as pointless or depressing. Only by understanding the basis for emotions can personalized strategies be developed to address negative emotions, and thus self management improved. Ultimately, care and decisions should be tailored to each patient, with the patient actively involved at the level at which they are comfortable and capable (Davis et al, 2005).

Doctors can refine their existing skills (see figure 3) in ways that allow them to attend better to the person of the patient as well as the patients' disease (Platt et al, 2001). Yet, in a Cochrane Collaboration review 'Interventions for providers to promote a patient centred approach in clinical consultations' (Lewin et al, 2007) it is not clear whether training health care providers to be more patient centred makes a difference to health care use or outcomes (Lewin et al, 2007). There are a large number of variables that influence a doctor's propensity to be patient centred (see attachment 2), not just knowledge.

### Figure 2 Patient centred consultation

Routine attention to the following aspects of the person's situation has been suggested as a way of ensuring that the consultations are patient centred:

- Explore people's social supports and physical environment, which may influence their health (e.g. smokers in the person's household, family attitudes to healthy behaviour change).
- Negotiate an agreed individualized written disease management plan, including specific strategies for dealing with acute symptomatic episodes.
- Find common ground for planning ongoing management so that the health professional and the patient can agree on what should be done.
- Find out whether and to what extent the person wants to participate in decision-making. This might be influenced by age, culture and education.

Source: National Asthma Council Australia, 2007

### Patient centred consultation

In a patient centred interview, often a request from the doctor to the patient, to 'tell me about yourself' will suffice. Developing a repertoire of carefully refined words is useful to conduct a patient centred interview. There are five main areas of concern:

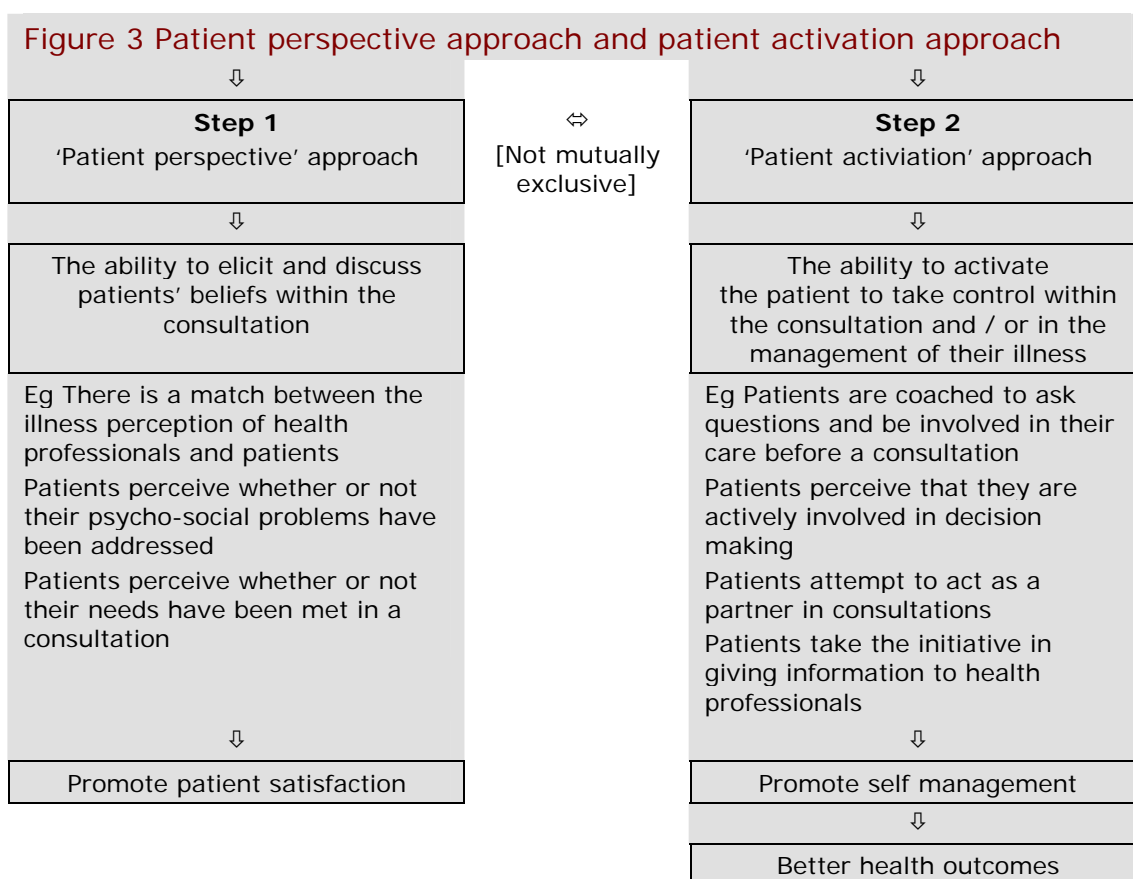
1. Who is the patient?
2. What does this patient want from the doctor? Today and in the long run?
3. How does this patient experience this illness?
4. What are the patient's ideas about the illness?
5. What are the patient's main feelings about the illness, with attention to five common responses: fear, distrust, anger, sadness, and ambivalence? (Platt et al, 2001).

### Patient perspective and patient activation

Michie, Miles and Weinman (2002) found that there are two separate but important ingredients of patient centred interviewing. These are:

1. The ability to elicit and discuss patient beliefs
2. The ability to activate the patient to take control in the consultation and / or in the management of their illness.

Both of these components may be crucial for producing positive outcomes from a consultation but they may differ in the type of outcomes which is affected. See figure 3. Health care professionals should develop their awareness of, and skills in achieving patient activation. This means finding ways of increasing the active role and control that patients take within, and consequently beyond the consultation (Michie, Miles, Weinman, 2002).



The 'patient activation' style is more strongly associated with better physical health outcomes than the 'patient perspective' style. Source: Michie, Miles, Weinman, 2002.

A doctor's nonverbal communication of attitude and feelings speaks as loud as what she says, and undivided attention is the strongest evidence of a desire to help the patient. Leaning slightly toward the patient, nodding, making eye contact, and using facilitative hums and murmurs all show interest. These techniques and supportive language are not instinctive. They may feel awkward at first (Platt et al, 2001).

### Patient centred communication

Patient centred care improves the quality and effectiveness of communication (National Diabetes Education Program, 2007). Communication should target the key decisions maker, the patient (Davis et al, 2005) and incorporate the following:

- A clear and understandable message
- A relevant and tailored content
- Culturally and linguistically appropriate format
- Reader, viewer or listener involvement
- Pilot testing on key audiences (International Alliance of Patients' Organizations, 2005).

## 2 Other styles of care

A range of clinical practice styles have been identified that polarized into those that were doctor centred and those that were patient centred.

Doctor centred clinical practice styles were defined as:

- Tightly controlled
- Using closed questioning techniques
- Defined in biomedical terms.

Patient centred styles, on the other hand, were seen as:

- Less authoritarian and paternalistic
- Giving greater attention to patients' own accounts and psychosocial aspects of patients' problems
- Holistic (Gillespie et al, 2002).

In doctor centred consultations the doctor's medical skills and knowledge predominate, reflected in behaviours such as direct and closed questioning of the patient and giving directions. These behaviours serve the doctor's control needs. Conversely, patient centred consultations reflect recognition of patients' needs and preferences, characterized by behaviours such as encouraging the patient to voice ideas, listening, reflecting and offering collaboration (Mead and Bower, 2000). Doctor centred care in which doctors try to get patients to do behaviours to meet goals that the clinicians believe are in their best interests is not conducive to success with a chronic disease such as diabetes (National Diabetes Education Program, 2007).

Development of the concept of patient centredness is linked to perceived limitations in the conventional way of practicing medicine, often labeled the 'biomedical model'. In the biomedical model the patient's illness is reduced to a set of symptoms to indicate the existence of disease processes which are investigated within a biomedical framework (Mead and Bower, 2000). Balint *at al* (1993) describe the biomedical model as 'one person medicine' in that a satisfactory clinical description does not require consideration of the doctor. By contrast, patient centred medicine is 'two person medicine' whereby the doctor is an integral aspect of any such description: 'the doctor and patient are influencing each other all the time and cannot be considered separately.' (Mead and Bower, 2000).

A patient centred model of care requires a shift from the traditional notion of the health professional (traditionally the doctor) being the dominant participant, with the patient passive, to one in which control is shared and power is redistributed. Attention is paid to the patient's personal experience of illness, and treatment provided as a result of a 'therapeutic alliance' between health professional and patient (Gillespie et al, 2002).

## 3 Patients' choice

Patient surveys and lay literature show that many patients are dissatisfied with the status quo and would prefer that doctors listened better and interact more with them as persons (Platt et al, 2001). Patients want more information and control (Gillespie et al, 2002). They want care which:

- Explores the patients' main reason for the visit, concerns, and need for information.
- Seeks an integrated understanding of the patients' world—that is, their whole person, emotional needs, and life issues.
- Finds common ground on what the problem is and mutually agrees on management.
- Enhances prevention and health promotion.
- Enhances the continuing relationship between the patient and the doctor (Stewart, 2001).

## 4 Doctors' actions

Regarding the question whether doctors practise patient centred care, data indicates that doctors vary but on the whole provide most patients with partially centred care (Stewart, 2001). Implicit in all innovations is the concept that some doctors will adopt them, others will think about them, and other will ignore them as long as possible (Bauman, Fardy, Harris, 2003).

While health professionals may claim to be practicing patient centred care, little is really known about what goes on between health professionals and patients in individual face-to-face encounters, and further research is needed in this underdeveloped area (Gillespie et al, 2002).

## 5 Benefits of patient centred care

Research regarding patient centred care has focused on a diverse range of outcomes (Michie, Miles, Weinman, 2002). See figure 4.

**Figure 4 Patient centred care potential health outcomes**

Health outcome	Description
Health status	The health status of a patient can be measured by physiological measures such as blood pressure and clinical assessments such as wound healing
Well being	The well being of a patient can be measured by patient self reports and assessments of their health and general quality of life
Healthcare behaviour	The healthcare behaviour relates to a patient's behaviour and attitude to their treatment. These include a change in behaviour such as adherence to therapies and self management of conditions through diet, lifestyle and/or therapies. Changes in healthcare behaviour can impact on other outcomes such as health status.
Patient centredness of healthcare	The health professionals or the patient can make an assessment of the patient centredness of healthcare in practice.
Patient satisfaction with healthcare	Patients, their families and / or carers can indicate their satisfaction with care.
Source: International Alliance of Patients' Organizations, 2005	

Although the evidence base examining the relationships between patient centred care and overall health is not substantial, it does indicate some positive outcomes. Bauman et al (2003) cites evidence that the patient centred approach leads to an increase in:

- Patient satisfaction
- Engagement and task orientation
- Reduction in anxiety
- Quality of life
- Doctor satisfaction
- Efficiency- resulting in fewer diagnostic tests and unnecessary referrals.

Holman and Lorig (2000) also found that taking the patient's view into account was associated with higher satisfaction, better compliance and greater continuity of care.

There is growing evidence that suggests doctors who focus on the patient as well as the disease are able to obtain more accurate historical data and develop more effective patient-doctor relationships (Platt et al, 2001). The mutual understanding leads to rapid diagnosis and negotiated

treatment options that are more likely to be adhered to (Lau, 2002). The possibility of misunderstanding and even medical error is greatly diminished (National Diabetes Education Program, 2007). It ought to be noted that the methodological quality of some of the studies is not high (International Alliance of Patients' Organizations, 2005). Studies apply different meaning of patient centred care making them difficult to compare and accurately assess the evidence base on patient centred healthcare (International Alliance of Patients' Organizations, 2005; Mead and Bower, 2000).

## 6 Chronic disease and patient centred care

Patient centred care is increasingly acknowledged by health professionals as an important focus in the care of people with long-term conditions (National Asthma Council Australia, 2007; Holman and Lorig, 2000). It means giving them the understanding and skills to optimize their investment of time in their condition to keep themselves well (National Asthma Council Australia, 2007). The key is to form a partnership with patients, allowing them to express their individual problems, fears and frustrations with having a chronic disease (Bauman, Fardy, Harris, 2003).

When acute disease was the primary cause of illness patients were generally inexperienced and passive recipients of medical care. Now that chronic disease has become the principal medical problem the patient must become a partner in the process, contributing at almost every decision or action level. This is not just because the patients deserve to be partners in their own health care (which, of course, they do) but because health care can be delivered more effectively and efficiently if patients are full partners in the process (Holman and Lorig, 2000).

Complex conditions require individualized management. When the patient's health problems don't fit management guidelines, health professionals must use all their skills to offer care that is tailored to the person, not the particular condition. Long-term conditions with complex management require more complex ways of interacting with the patient to ensure adherence to agreed treatment plans and improve quality of life and clinical outcomes (National Asthma Council Australia, 2007).

Australian health care is in transition from a system set up to manage acute disease to a system organized for effective prevention and control of chronic conditions (National Asthma Council Australia, 2007). The promotion of patient centred care is a central aim of the improvement in health service delivery outlined in the National Chronic Disease Strategy (NCDS) and the National Service Improvement Frameworks (NSIF) for asthma, cancer, diabetes, heart, stroke and vascular disease (National Asthma Council Australia, 2007).

## 7 Diabetes and patient centred care

As a chronic disease, diabetes has a self management regime that is one of the most challenging of any chronic illness (Oswald and Hilditch, 2007) because of the need for multiple behavioural changes, as well as multiple psychological adjustments (Bauman, Fardy, Harris, 2003). As much as 95% of diabetes care is self care (Association of the British Pharmaceutical Industry, 2006), that means that the majority of their care is their own responsibility (Association of the British Pharmaceutical Industry, 2006). In reality it is the patients who make the important choices that affect their health and well being, and indeed it is the patient who is in control and experiences the consequences of his or her choices (National Diabetes Education Program, 2007).

In theory, when informed patients take an active role in managing their diabetes, and providers are prepared, proactive and supported with time and resources, their interaction is likely to be productive. Patient centred care can lead to:

- Better diabetes care
- More efficient practices
- Healthier patients
- More satisfied patients and providers.

Bauman (2003) asserts that positive outcomes for diabetes patients undergoing patient centred interventions can be produced without lengthening consultations, especially if a team approach to management is developed. Collaborative diabetes management, with the patients as the key player, will help to improve communication and encourage shared decision-making, thus improving the likelihood that the patient will succeed in self care (National Diabetes Education Program, 2007).

Some trials of patient centred care have not achieved better control of diabetes, healthier lifestyles or knowledge of self care. Kinmonth (1998) warns that these findings are clear signals to remind clinicians committed to the benefits of patient centred care that they should not lose the essential focus on disease while paying attention to the unique needs of the individual patient.

Patients view several aspects of diabetes therapy as very burdensome, especially insulin injections and self monitoring of blood glucose (Vijan, Hayward, Ronis, Hofer, 2005). There is, at present surprisingly limited information on patients' views of the burden of self management and how these views may affect treatment adherence (Vijan, Hayward, Ronis, Hofer, 2005). For example, some patients refuse insulin, when recommended, primarily because of their views of the burden of the regimen (Vijan, Hayward, Ronis, Hofer, 2005).

Patient self management is a critical factor in achieving optimal diabetes care (Vijan, Hayward, Ronis, Hofer, 2005).

## 8 Self management and patient centred care

Evidence supports individual components of patient centred care, such as self management training (Bauman, Fardy, Harris, 2003).

Self management education has been developed to enhance the ability of patients with chronic disease to participate in their health care. It places patients in a central role. Self management addresses continuous use of medication, behaviour change, pain control, adjusting to social dislocations, coping with emotional reactions, learning to interpret changes in the disease and its consequences, and the use of medical and community resources (Holman and Lorig, 2000). Three elements to effective patient self management are:

1. Patients must be well informed about their disease (and beyond this they must not just have the knowledge but also understand how to use it i.e. be able to adapt the knowledge for their purpose).
2. They must know where they can access treatment.
3. They must have greater control over their treatment (Davis et al, 2005).

Well defined approaches such as the Stanford Chronic Disease Self-Management Program and the Flinders Model of Chronic Disease Self-Management are based on these principles (National Asthma Council Australia, 2007).

Chronic disease self management programs are increasingly being adopted as a structural approach to patient centred care (National Asthma Council Australia, 2007; Jordan, Nankervis, Brand and Osborne, 2006) providing patients with the confidence and skills for the management of their chronic condition as well as the effective negotiation of the health care system. Participant's experience:

- Reduced symptoms
- Improved physical activity
- Less need for medical treatment
- Growth in confidence in their ability to cope with their disease (Holman and Lorig, 2000).

Unfortunately, only a small percentage of patients are willing to go along to group education (National Asthma Council Australia, 2007).

Health coaching is an emerging approach based on patient centred principles. It focuses on action plans set by the person with the condition. Coaching generally involves a health professional, other than the main clinician, who provides individualized support for self management (National Asthma Council Australia, 2007).

## 9 General practice and patient centred care

A patient's beliefs, knowledge and feelings play an integral part in the decision to visit a doctor. A patient centred general practitioner is aware of these factors and tries to enter the patient's world and see the illness through the patient's eyes. This involves the doctor understanding not only the reason for the consultation, but also the patient's expectations (see figure 5) of the consultation's process and outcome (Law and Britten, 1995).

Figure 5 Consumers' expectations of general practice

- Better communication with GPs, including the opportunity for open discussions within the consultation about diagnosis, treatment options and medical terminology, and to get more information if desired.
- A choice of GPs, catering for a range of cultural and gender-related preferences.
- A GP who treats them with respect.
- Clear information about their disease condition, all relevant treatment and medical options, in both written and spoken formats.
- The opportunity for discussion with the GP about referrals, further medical tests and related options.
- The opportunity to ask information of and share information with the GP about allied health professionals, community health services and other health professionals.
- Information at the time of consultation about costs of the visit, treatment and prescriptions.
- Access to language interpreter services for those who need them.
- Access to special care and communication strategies for those with a hearing impairment, intellectual disability or other special needs.
- Bulk-billing options to ensure equity of access.
- GP-initiated links with community support services.
- Access to more shared care between GPs and other disciplines.
- More communication between GPs and consumer organizations.
- An emphasis on illness prevention and health promotion, including access to education sessions.
- After hours services provided by their own GP practice.
- The opportunity to contact the GP by telephone as necessary.
- Reasonable waiting times at the practice.
- Easy physical access to the practice.
- Clear, accurate and easily understood medical records, written information and instructions including prescriptions.
- Access to personal health information.
- Appropriate recall systems.
- Use of information technology to provide patients and doctors with relevant information on the most appropriate treatment.

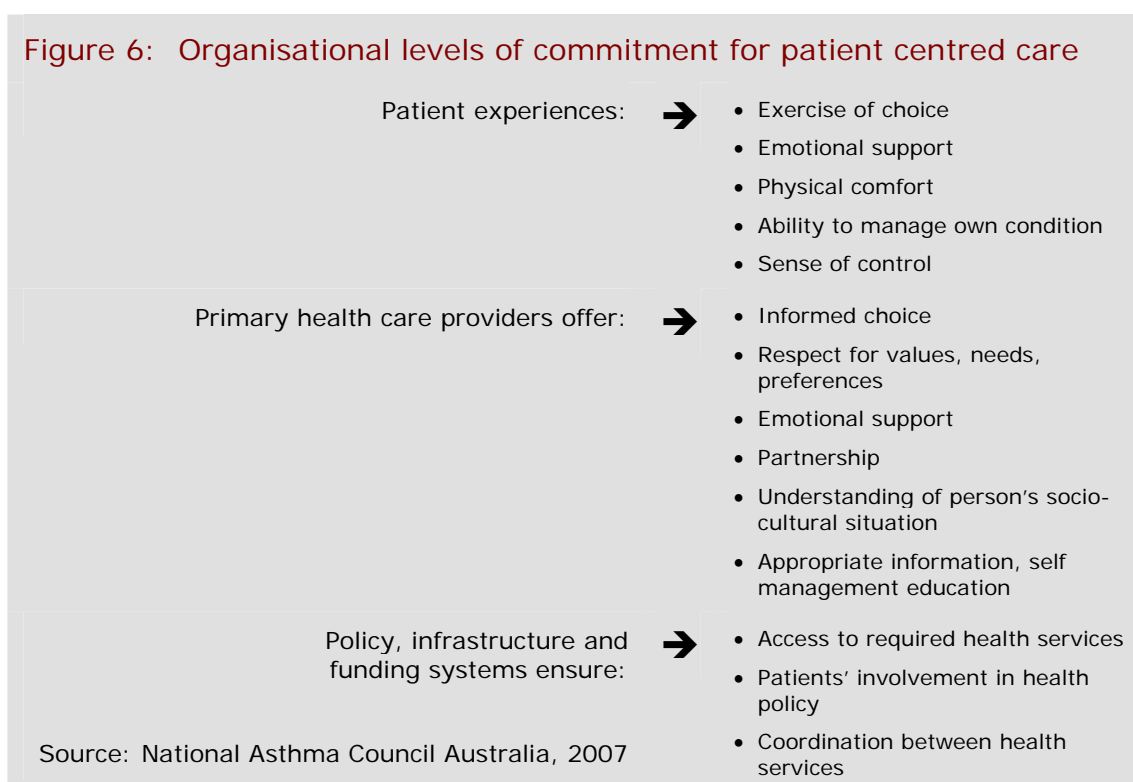
Source: Consumers Health Forum, 1999

Limited time during the consultation is often cited as a reason GPs cannot provide patient centred care. Strategies for making the best use of the time available include the following:

- Organising the practice so that an appropriately trained nurse can provide the disease-specific information patients want.
- Making sure patient know that pharmacists can provide expert advice on medications and side effects. For those with complex medication regimens, a home medicines review may enable people to discuss their concerns in full. Allowing a person to discuss their fears about medications, and gain reassurance on what to expect, can lead to better adherence.
- Giving patients information before the consultation, e.g. disease-specific information or a leaflet inviting them to list all their questions to bring to the consultation.
- Collecting medical history in advance, e.g. by the practice nurse (National Asthma Council Australia, 2007).

Teamwork is recognized as an aspect of patient centred care. One service provider cannot feasibly undertake all aspects of a person's care such as comprehensive motivational interviewing, patient education for self management, dietary assessment or coaching to achieve behavioural change (National Asthma Council Australia, 2007). For example, patient centred care for diabetes may involve the general practitioner, a specialist, a dietitian, a diabetes nurse educator, a podiatrist working with the patient.

**Figure 6: Organisational levels of commitment for patient centred care**



## 10 Patient centred services and systems

Health systems require the involvement of individual patients who adhere to their treatments, make behavioural changes and self manage (International Alliance of Patients' Organizations, 2006).

Davis et al (2005) propose that a patient centred health system would have the following characteristics:

- Superb access to care: ease of making an appointment; ability of patients to select the day and time of their appointment themselves; short waiting times in office.
- Patient engagement in care.
- Clinical information systems that support high-quality care, practice-based learning and quality improvement.
- Care coordination.
- Integrated, comprehensive care and smooth information transfer across a fixed or virtual team of providers.
- Ongoing, routine patient feedback to a practice.
- Publicly available information on practices so that a patient could choose a physician or a practice most likely to meet the patient's needs.

Others have proposed a patient centred practice that provides patients with a medical home and an expected basket of services, including a patient centred team approach, elimination of barriers to access, advanced information systems including an electronic health record, more functional offices, a focus on quality and outcomes, and enhanced practice finance (Davis et al, 2005). The International Alliance of Patients' Organizations (2006) have established their own principles for patient centred health-care (see attachment 3).

Within the health system, patient centred care involves designing services in a way that responds to individuals' preferences, values and needs (National Asthma Council Australia, 2007; International Alliance of Patients' Organizations, 2005). This could be achieved with a comprehensive system of patient education where patients and the health care professionals collaborate as a team, share knowledge and work toward the common goals of optimum healing and recovery (Grin, 1994).

At an organisational level (see figure 6, page 19), implementing a patient centred approach requires structural changes (Ponte et al, 2003) and an up-front investment in relationship building. For patient centred care to be effectively implemented in health care, providers must honestly assess how they are currently treating their patients and how this can change (National Diabetes Education Program, 2007).

Assessment tools exist, to measure the patient centredness of an organization. See attachment 4.

## 11 Barriers

There are numerous barriers to the practice of patient centred healthcare, held by health professionals and patients.

Some patients lack the confidence to question their doctor (Association of the British Pharmaceutical Industry, 2006), for example, individuals who are disempowered in every other aspect of their lives (financially, educationally, and especially if they are women). They cannot take control (Gillespie et al, 2002). Patients may not have the necessary skills to take in, analyse or use the information they are given to make decisions. So knowledge, education and access to quality information can also be barriers to patient centred care and may lead to inequalities between those of different age groups and or socio-economic status (International Alliance of Patients' Organizations, 2005).

Clinicians may find it difficult to go beyond disease centred clinical encounters. Low staffing levels and low morale, along with medical training that does not equip doctors to deal with the patient's expression of values, ideas, or feelings, lead to clinical consultations that focus on understanding only the patient's disease. Even well-motivated clinicians may find that they are uncomfortable with and untrained to respond to the person of their patient (Platt et al, 2001; Davis et al, 2005).

Initially, some doctor may see a patient centred approach as impractical, claiming that there is insufficient time to learn more about the person of the patient. However, a skilled doctor can obtain a useful sketch of a patient as a person in less than a minute (Platt et al, 2001). Evidence indicates that patient centred interviews do not take longer than a regular consultation (International Alliance of Patients' Organizations, 2005), and may save time (Platt et al, 2001). A UK study found that, if uninterrupted, patients' initial explanation of the reason for the visit takes 1.5 minutes on average, and that 78% of people will stop talking within 2 minutes of the beginning of the consultation (Langewitz, 2002).

Patient centred care is perceived to be difficult to implement. It can become a low priority as outcomes are less clearly related to immediate health gain (Bauman, Fardy, Harris, 2003).

## D Conclusion

The challenge for patient centred care is to focus on:

- Health rather than on disease
- Prevention and health education rather than on cure
- Trying to make people aware of the choices they have in relation to their health (Lau, 2002).

Because each patient's experience of illness is unique, it seems obvious that the care would include attention to the patient's motivation, values, desires and feelings. While patients want more control and support this approach, there are issues to further consider.

### **Strength of the evidence**

The evidence on the benefits of patient centred care is not substantial or conclusive. It does indicate outcomes such as increased patient and doctor satisfaction, better compliance and greater continuity of care. Yet, some patient centred care trials have not achieved positive outcomes and recommend that clinicians should not lose focus of the disease, while paying attention to the unique needs of the patient.

### **Capacity to change**

Even when provided with training, it is not clear if doctors become more patient centred. Even so, doctors already provide most patients with partially patient centred care. When 'doctor centred care' is practiced, attitudinal change is needed to redistribute power and shift from the traditional notion of the health professional being the dominant participant to one in which power and control are shared.

At an organisational level, implementing a patient centred approach requires structural changes so that patients: have access to required services and information; are involved in policy development; and receive coordination between health services. These system changes can be difficult for a health service to make when the outcomes are not clearly related to immediate health gain.

### **Not all patients will benefit from more control**

Patients may not have the confidence to question their doctor. They may not have the necessary skills to take in, analyse or use the information they are given to make decisions.

Patients, their families and carers may need education so that they can decide and articulate what care they need and want and healthcare professionals need competencies to practice patient centred care.

One message is clear, patient centred care meets the needs of people with long-term conditions who are required to self manage. Patient activation assists patients to take control as partners in their health care.

Recent drivers of patient centred care include economic constraints on health care, reduced hospital stays, increases in shared care and a broadened community base for chronic disease management (Bauman, Fardy, Harris, 2003). The health systems will increasingly rely on the involvement of the patient—to adhere to treatment, make behavioural changes and to self manage. Especially as patient centred care is a cost-effective way to improve health outcomes for the growing number of patients with chronic conditions (International Alliance of Patients' Organizations, 2005).

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## Attachment 1 Definitions and concepts

Various definitions and concepts of patient centred care are listed below.

Core concepts of patient centred care:

- Dignity and respect: health care practitioners listen to and honor patient and family perspectives and choices. Patient knowledge, values, beliefs and culture are incorporated into the planning and delivery of care.
- Information sharing: health care practitioners communicate and share complete and unbiased information with patients in ways that are affirming and useful. Patients receive timely, complete, and accurate information in order to effectively participate in care and decision making.
- Participation: patients are encouraged and supported in participating in care and decision making at the level they choose.
- Collaboration: Patients and families are also included on an institution-wide basis. Health care leaders collaborate with patients and families in policy and program development, implementation and evaluation, as well as in the delivery of care (Institute for Family-Centred Care, 2007).

The Picker Institute Europe (2004) defines patient centred care in the following way:

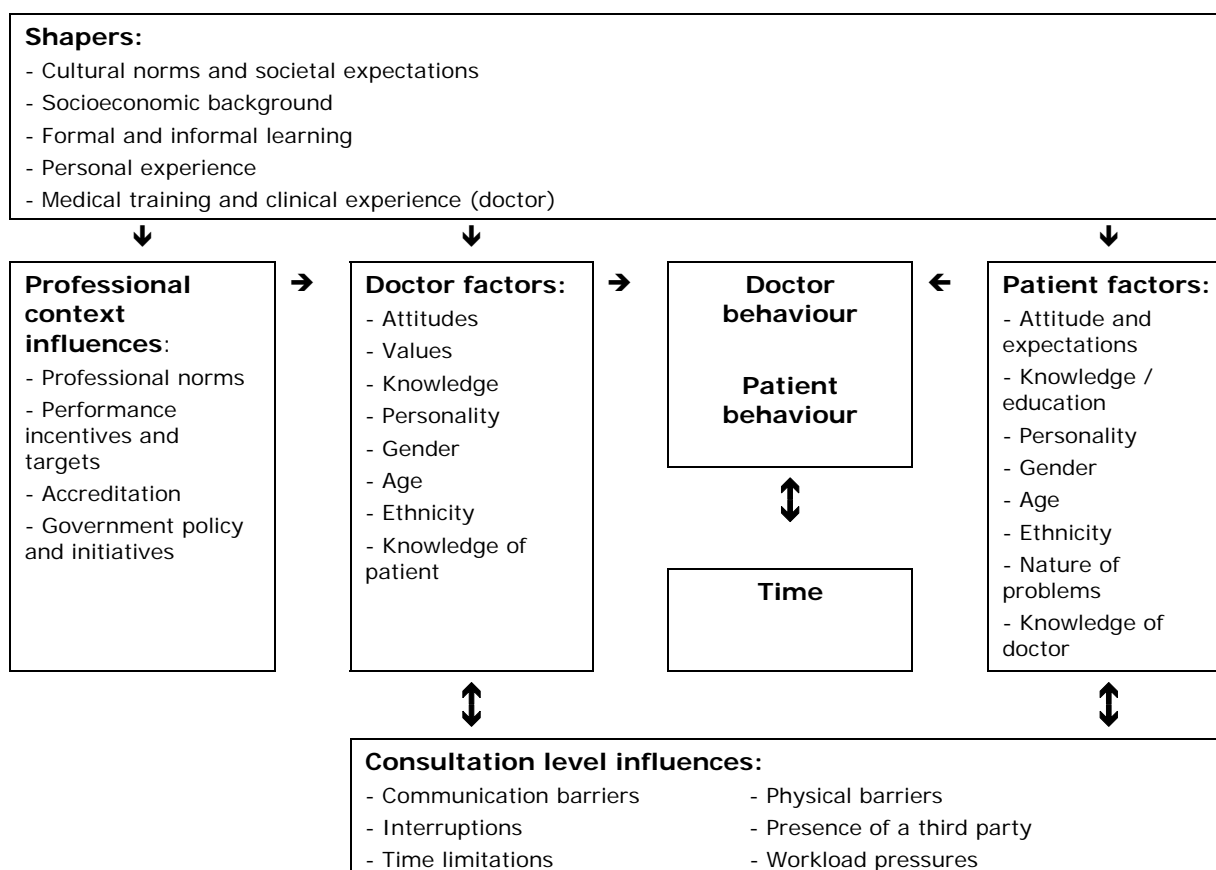
- Informing and involving patients, eliciting and respecting their preferences.
- Responding quickly, effectively and safely to patients' needs and wishes.
- Ensuring that patients are treated in a dignified and supportive manner.
- Delivering well coordinated and integrated care.

The National Health Council (listed in International Alliance of Patients' Organizations, 2005) defined three principles of patient centred care as:

- Patients and their families manage their health care in partnership with a coordinated health care team that recognizes, respects and acts upon their goals, needs, values, preferences, cultural wishes, and/or other factors identified by patients and their families.
- Patients and their families receive evidence based, cost effective care that maximizes health, alleviates discomfort and is safe and free from avoidable errors.
- Patients and their families have the ability to obtain and understand health information and services, and make appropriate health decisions.

## Attachment 2 Variables

A large number of variables potentially influence a doctor's propensity to be patient centred. (Mead and Bower, 2000).



Female doctors could be more likely than male doctors to involve their patients in decision making and thus be able to create an atmosphere for more effective communication in the consultation (Law and Britten, 1995).

## Attachment 3

# Patient centred health-care

### The Declaration on Patient-Centred Healthcare

Patient centred healthcare must be based on five principles:

1. Respect – Patients and carers have a fundamental right to patient centred healthcare that respects their unique needs, preferences and values, as well as their autonomy and independence.
2. Choice and empowerment – Patients have a right and responsibility to participate, to their level of ability and preference, as a partner in making healthcare decisions that affect their lives. This requires a responsive health service which provides suitable choices in treatment and management options that fit in with patients' needs, and encouragement and support for patients and carers that direct and manage care to achieve the best possible quality of life. Patients' organisations must be empowered to play meaningful leadership roles in supporting patients and their families to exercise their right to make informed healthcare choices.
3. Patient involvement in health policy – Patients and patients' organisations deserve to share the responsibility of healthcare policy-making through meaningful and supported engagement in all levels and at all points of decision-making, to ensure that they are designed with the patient at the centre. This should not be restricted to healthcare policy but include, for example, social policy that will ultimately impact on patients' lives.
4. Access and support – Patients must have access to the healthcare services warranted by their condition. This includes access to safe, quality and appropriate services, treatment, preventive care and health promotion activities. Provision should be made to ensure that all patients can access necessary services, regardless of their condition or socio-economic status. For patients to achieve the best possible quality of life, healthcare must support patients' emotional requirements, and consider non-health factors such as education, employment and family issues which impact on their approach to healthcare choices and management.
5. Information – Accurate, relevant and comprehensive information is essential to enable patients and carers to make informed decisions about healthcare treatment and living with their condition. Information must be presented in an appropriate format according to health literacy principles considering the individual's condition, language, age, understanding, abilities and culture.

Source: International Alliance of Patients' Organizations, 2006

# Attachment 4

## Assessment tool for patient centred care

Organisational self assessment tool: elements of patient- and family-centred care

Domain	Element <sup>1</sup>	Yes	+/-	No
Leadership and operations	Clear statement of commitment to PFCC and PF partnerships			
	Explicit expectations, accountability, measurement of PFCC			
	PF inclusion in policy, procedure, program, guideline development, Governing board activities			
Mission, vision and values	PFCC included in mission, values and/or core values			
	PF 'friendly' patient bill of rights and responsibilities			
Advisors	PF serve on hospital committees			
	PF participate in quality and safety rounds			
	Patient and family advisory councils			
Quality improvement	PF voice informs strategic / operational aims and goals			
	PF active participants on task forces, QI teams			
	PF interviewed as part of walk-rounds			
	PF participate in quality, safety and risk meetings			
	PF part of team attending IHI, NPSF and other meetings			
Personnel	Expectation for collaboration with PF in job descriptions and PAS			
	PF participate on interview teams and committees			
	PF welcome new staff at new employee orientation			
	Staff/physicians prepare for and supported in PFCC practice			
Environment and design	PF participate fully in all clinical design projects			
	Environment supports patient and family presence and participation as well as interdisciplinary collaboration			
Information and education	Web portals provide specific resources for PF			
	Clinician e mail access from PF is encouraged and safe			
	PF serve as educators/faculty for clinicians and other staff			
	PF educated to campaign fact sheets			
	PF access to / encouraged to use resource room			

<sup>1</sup> Codes: PFCC=patient- and family centred care; PF=patient and family; PAS=performance appraisal system

<b>Diversity and disparities</b>	Careful collection and measurement: race / ethnicity / language			
	PF provided timely access to interpreter services			
	Navigator programs for minority and under-served patients			
	Educational materials at appropriate literacy levels			
<b>Charting and documenting</b>	PF have full and easy access to paper and electronic records			
	Patient and family are able to chart			
<b>Care support</b>	Family members of care team, not visitors, with 24/7 access			
	Families can stay, join in rounds and change of shift report			
	PF find support, disclosure, apology with error and harm			
	Family presence allowed/supported during rescue events			
	PF are able to activate rapid response systems			
	Patients receive updated medication history at each visit			
<b>Care</b>	PF engage with clinicians in collaborative goal setting			
	PF listened to, respected, treated as partners in care			
	Actively involve families in care planning and transitions			
	Pain is respectfully managed in partnership with PF			
	PF active participants in all campaign interventions			

Source:  
Institute for Healthcare Improvement at [www.ihl.org](http://www.ihl.org) (accessed Aug 2007)