

Working in partnership with patients — what does it mean in clinical practice?

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Abstract

Working in partnership with patients as part of person-centred care is a key aspect of high-quality care. It is not only a professional requirement, but also something patients increasingly demand. This article explores some of the key concepts and, using the situation of a patient, 'Betty' as an example, the skills and approaches needed for clinicians to be able to do this in practice.

Keywords Long-term conditions; medical professionalism; partnership working; person-centred care; shared decision-making; support for self-management

Introduction

Ideas around person-centred care (PCC) have been with us for more than two decades. There are sessions about it at most health conferences, journals contain articles discussing its merits, and the National Institute for Health and Care Excellence includes decision support in some of its guidance. Nonetheless, for people like Betty (Table 1), delivering PCC in routine clinical settings is complex.

Using Betty's story, we will explore how we can work with her to manage her sometimes complex health problems and to make plans and decisions together that Betty is confident meet her personal, as well as health, preferences and needs. We will discuss why this is worth doing, how to respond to some of the barriers and difficulties, and what this means for the changing roles of doctors and patients.

What is person-centred care?

The Royal College of Physicians describes PCC as a 'set of attitudes, roles, and skills, supported by tools and organizational systems, which put patients and carers into a full partnership relationship with clinicians in all clinical interactions'.¹ The

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Key points

- People with health problems respect and value health professionals, but up to half want more involvement in decisions and plans for their care
- People are the main agents in delivering their care day-to-day
- Person-centred care is a response to this and is a key professional attribute
- It helps people to manage their health better, and is more rewarding for clinicians
- Patients, the General Medical Council and the law expect a much more collaborative relationship between clinicians and patients
- This requires changes in attitudes, skills and systems
- It is likely to be assessed in undergraduate and postgraduate examinations

Health Foundation² identifies that PCC needs to be personalized, coordinated, enabling and delivered with dignity, compassion and respect (Figure 1).

What is clear is that the outcomes are highly individual and context-dependent. They may result in a decision to act (or not act), a plan for treatment, provision of education and training, or peer support, some of which may best be provided in a non-healthcare setting (e.g. the voluntary or third sector). Whatever the definition, for PCC, consultations between clinicians and patients should be a two-way process between equal partners, each providing vital input to reach the best outcomes (Figure 2).

What does this mean for Betty?

Betty lives with the complexity of several long-term conditions. In some clinical encounters, she may feel supported and able to articulate her concerns and preferences. However, we know that decisions around Betty's next steps will often be determined by the setting, specialty, expertise and preferences of the clinician or team she is interacting with, more than by Betty. Betty may feel bewildered by the system, be given apparently conflicting or even contradictory advice and be unsure of the reasons for the components of her regime or the benefits and trade-offs of any changes. To make good decisions and plans with Betty, some key additional information is therefore needed that cannot be known to her clinicians without asking (Table 2).

Making partnership happen

People manage their health almost all of the time outside the healthcare setting. They have limited contact with health professionals. When they do, it is not always at the moment of greatest need (Figure 3). This means that the person best placed to know what decisions or plans will work best for Betty is Betty

Betty's situation

Betty is 74 years old. She has type 2 diabetes mellitus, arthritis, hypertension, chronic obstructive pulmonary disease (COPD; she is an ex-smoker) and a body mass index of 32 kg/m².

She is taking gliclazide 160 mg twice daily, pioglitazone 45 mg daily, simvastatin 80 mg daily, aspirin 75 mg daily, ramipril 5 mg daily, bendroflumethiazide 2.5 mg daily, lansoprazole 15 mg daily and ventolin and fluticasone inhalers.

Betty's peak expiratory flow rate is 70%, oxygen saturation 92% on room air, glycated haemoglobin 78 mmol/mol, cholesterol 5.6 mmol/litre and blood pressure 154/95 mmHg.

What does Betty need next?

More diabetes treatments? More blood pressure treatments? Advice about diet and exercise? A pulmonary rehabilitation programme? A COPD rescue pack to avoid admissions? More regular general practitioner (or specialist) visits? Several or all of the above?

Table 1



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Figure 1 Principles of person-centred care.

herself. The contact Betty has with health professionals is a precious and infrequent opportunity to obtain information and support, discuss her concerns and priorities, and be able to work out what she needs from health professionals, and others, to make sure she can do what matters most to her (Table 2).

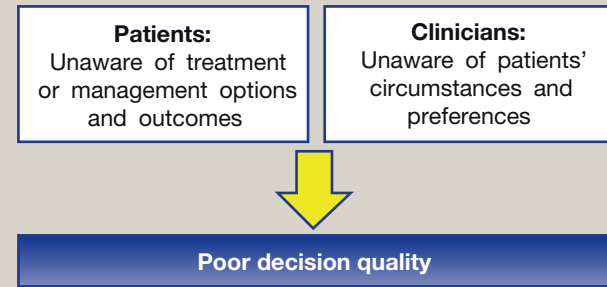
Although many clinicians aspire to PCC, patient feedback shows that it is not happening consistently or systematically. Between one-third and one-half of patients want more involvement in plans and decisions about their care. Those who are more involved are happier with decisions and more likely to use medications successfully. Addressing this mismatch is at the heart of PCC and we must deal with three sets of obstacles.

Culture

There is a culture among professionals, and to some extent among patients, that the doctor–patient relationship is one of

Shifting the balance of clinical conversations

What we do now



A person centred approach



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Figure 2

paternalism and dependence. Some feel that technical advances and system complexity make this inevitable, but there is a good deal of discomfort with this view among patients and patient representative groups. There is a recognition that much more can be done, and that the current approach needs to change for the UK National Health Service (NHS) to be efficient and effective.³

The difficulty of cultural change should not be underestimated. PCC is dependent on physicians seeing their role as helping patients to make real choices that work better from their perspective, rather than telling them what is best. This is not just about providing more information, but about giving Betty what

What really matters to Betty

- Her grandchildren are growing up; in particular Kate, 18 years old, is having a hard time with her peer group. Kate really only opens up to Betty
- Alf, Betty's husband, is in a local care home and Betty has difficulty getting to the home to visit
- Betty gets low and sometimes feels lonely. She wants to be able to keep her independence and her own home
- She gets short of breath easily but sometimes gets a sore throat and thrush from using her inhalers
- Betty wants to be able to meet up with her church friends and get to her painting class

Table 2

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