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Patient-centred care as an approach to improving health care in Australia

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ABSTRACT

Patient-centred care (PCC) has emerged as a primary approach to health care. This approach emphasises partnerships in health between patients and healthcare professionals, acknowledges patients' preferences and values, promotes flexibility in the provision of health care and seeks to move beyond the traditional paternalistic approach to health care. Thus, in addition to the physical aspects of health care, the PCC approach acknowledges a patient's beliefs and values towards wellbeing. One advantage of the PCC approach is its focus on enhanced patient satisfaction; however, recently, concerns have been raised as to the effects of the PCC on the evidence-based care approach, as the two approaches are viewed as mutually exclusive rather than complementary. The paper discusses the concept of PCC and considers its benefits both in relation to patients and health care organisations. It also considers the contribution of nurses to PCC and in the enhancement of service delivery.

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Contents

1. Introduction.....	00
2. Patient-centred care in preference to paternalism.....	00
3. The benefits of patient-centred care.....	00
4. Patient-centred care approach to enhance service delivery.....	00
5. Operationalising patient-centred care approach in nursing.....	00
6. Conclusion.....	00
Conflicts of interest.....	00
Acknowledgements/Disclosures.....	00
References.....	00

1. Introduction

The provision of health care has evolved from applying a traditional paternalistic approach of 'doctor knows best' to a patient-centred care (PCC) approach. Under the traditional paternalistic approach, medical practitioners instructed and prescribed treatments with limited input from patients and families. Conversely, today, research studies recognise the importance of a PCC approach in the delivery of health care. Indeed, governments (Australian Commission on Safety and Quality in Health Care (ACSQHC), 2011; National Health Service, 2005; US Department of Health & Human Services, 2008), the World Health Organisation

(2000) and other health policy organisations (e.g., the National Research Corporation [NRC] Picker, 2008; Picker Institute, 2004) advocate and endorse the need for health care institutions to place greater emphasis on the individual. The major objective of PCC is to achieve a working partnership between patients and families in relation to the delivery of health care services.

There is no universally agreed upon definition of PCC; however, it is embedded within the paradigm of holism that views individuals as a biopsychosocial and physiological whole (Ekman et al., 2012). Holism seeks to ensure that the needs of individuals accessing health care services are met with respect and responsiveness and, in relation to the making of clinical decisions, it is a paradigm grounded in concepts of values, personal preferences and partnerships (Institute of Medicine, 2005).

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The Picker Institute (1993) brought PCC to the forefront with its research that emphasised the need to respect patients' preferences and values, psycho-physiological comfort, the importance of communication and the need to provide support and coordinated care that is inclusive of the patient and his/her family. Due to its ability to be flexible and tailored to meet individualised needs, this approach has enhanced the quality of health care and has become an independent measure of the quality of health care services being provided (ACSQHC, 2011). The idea of PCC is reflected in the presupposition: 'nothing about me, without me' (Delbanco et al., 2001).

2. Patient-centred care in preference to paternalism

The principles of PCC are reflected in the mission statements of many health service providers that espouse the qualities of respecting patients' beliefs and values, open communication and support. In the Australian health care setting, PCC has been practised for over a decade and is reflected in the Australian Charter of Health Care Rights (ACSQHC, 2007) and the Australian Safety and Quality Framework for Health Service Standards (2011). These documents provide patients' with information on the care standards that they can expect from an organisation and reaffirm the core PCC principle that an individual is central and integral to his/her care and should be consulted before any decisions about treatment are made. The primary principles underpinning PCC reflect the ethical paradigms of autonomy and the right to self-determination; however, it should be noted that some health care providers have grappled with the implementation of PCC focused approaches.

The traditional paternalistic approach to health care has received extensive criticism due to its focus on decisions being made by the medical fraternity (i.e., medical practitioners, positioned as experts around whom a health care organisation's workflow is based and who define the constructs of an organisation's perceptions of health care) (Rodriguez-Osorio & Dominguez-Cherit, 2008). Paternalism is characterised by a usurpation of decision-making power that gives little consideration to an individual's preferences; rather, the decisions reached are primarily based the opinions and preferences of medical professionals (Buchanan, 2008). As an approach, it focuses on the disease and its management rather than the individual and his/her family and what they value as important (Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001). It lacks parity between the doctor and patient and can compromise a patient's rights to self-determination and autonomy. The tenets of these two principles; self-determination and autonomy, support the development of a therapeutic alliance based on respect for each individual's competences, decision-making abilities and personal values and preferences (Entwistle, Carter, Cribb, & McCaffery, 2010; Mackenzie, 2008; Ryan & Deci, 2000). Recently, health care organisations and clinicians have become more receptive to PCC and have acknowledged its ability to enhance the safety and quality of care provided.

3. The benefits of patient-centred care

Supporting participation along with a greater emphasis on communication can lead to shared collaborations and decision-making processes. Rather than viewing a patient as a passive component of the medical process, PCC adopts a contractual view of health care under which a patient is viewed an active participant who should be involved in any decision-making processes (Leplege et al., 2007). The shift to PCC enhances concordance between health care providers and patients' adherence to treatment plans (Roumie et al., 2011; Thompson & McCabe, 2012), improved health outcomes and increased patients' satisfaction with healthcare services (Bertakis & Azari, 2011; Ekman et al., 2012). The adoption

of PCC practices in primary health care has resulted in significant benefits for patients, as patients can better manage their health when they are informed and supported. Bertakis and Azari (2011) showed that a PCC approach significantly reduced patients need to access speciality care ($p < 0.0209$), hospitalisations ($p < 0.0033$) and required fewer pathology investigations ($p < 0.0027$). Similarly, the adoption of a PCC approach in the health management of patients with chronic hypertension led to an increase in medication adherence (RR 3.19, 95% CI 1.44, 16.23) (Roumie et al., 2011). Other benefits related to PCC, including improving patients' self-perceptions, reducing stress and increasing empowerment, have also been reported in diabetes management (Anderson, Funnell, & Butler, 1995; Hermanns, Kulzer, Ehrmann, Bergis-Jurgan, & Haak, 2013; Kinmonth, Woodcock, & Griffin, 1998).

Programmes that employ established PCC approaches (e.g., in cardiac and respiratory rehabilitation) endeavour to empower patients to make lifestyle modifications, and improve their overall health and wellbeing. Conversely, traditional management strategies focused on illness, interventions and pharmacology and have limited strategies on how to optimise health. Adjusting the focus of clinical care to accommodate the needs of patients has reportedly enhanced patients' experiences (Cegala Street, & Clinch, 2007; Coulter, Parsons, & Askham, 2008; Robinson, Callister, Berry, & Dearing, 2008), decreased the lengths of hospital stays and readmission rates, enhanced primary health care services and improved patients' functional capacities (Anderson et al., 1995; Bertakis & Azari, 2011; Hermanns et al., 2013; Kinmonth et al., 1998). The outcomes attributed to PCC suggest that the approach benefits both consumers and health care organisations.

Despite the benefits of PCC in relation to patients' levels of satisfaction, concerns have been raised as how this approach affects evidence-based health care practices. The two approaches have been traditionally been viewed as being mutually exclusive rather than complementary (Pollock & Grime, 2003). However, proponents of the evidence-based health care approach concede that medical practitioners need to consider and recognise what is meaningful to patients. The importance of acknowledging patients beliefs has been increasingly recognised through the promotion of patient advocacy (e.g., respecting patients' choices initiatives) that aims to promote communication in relation to advanced health care planning (APC). APC supports patient advocacy, the right to self-determination and permits patients to make decisions and have input into future health care decisions even, if in the future, they have a limited capacity to do so. Such initiatives reduce disparities in the judgement of patients, families and health care decision makers (Balsa, Seiler, Thomas, & Bloche, 2003).

Differences of opinions on medical treatment and a patient's right to self-determination can be challenging and may cause patients to decline medical interventions and treatment in favour of alternative medicines (Verhoef & White, 2002). In such cases, health care professionals need to ensure that they provide the patient with the necessary medical information and support and understand that the patient's decisions are reflective of his/her own values and preferences. Research suggests that many patients' are subjected to treatments that are deemed futile, impose additional stress upon the patient and his/her family and can cause caregivers to feel morally distressed (Teno et al., 1997; Walling et al., 2010). The relentless pursuit of medical treatment and interventions could potentially compromise an individual's perceptions of quality of life and dignity at the end of life and thus should not be pursued at any cost.

Huynh et al. (2013) investigated the frequency of treatments provided to patients admitted to an intensive care unit (ICU) that were deemed futile and found that 20% of the patients admitted received treatments that did improve their overall survival rates or quality of life. Further, these treatments had financial repercus-

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