Getting it right: why bother with patient-centred care?

Adrian E Bauman, H John Fardy and Peter G Harris

ABSTRACT

- Patient-centred care is about sharing the management of an illness between patient and doctor; it is not new but is increasingly evidence-based, especially for chronic problems such as diabetes, asthma and arthritis.
- Systematic reviews show that patient-centred care results in increased adherence to management protocols, reduced morbidity and improved quality of life for patients.
- Key features of the doctor–patient interaction are shared goal setting, written management plans and regular follow-up.
- Supportive community-based services and programs, combined with healthcare system commitment, are also required to make this approach effective in improving population health.

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HOW TO REDUCE THE BURDEN of chronic illness and how to help people with diseases such as diabetes, arthritis and asthma remains a challenge. The traditional, didactic "medical model" approach to the doctor–patient interaction, which focuses on the disease rather than the person with the disease, will not reduce total morbidity from these diseases. When medical management comprises more than a single pill, more complex methods of interacting with, and partnering, patients are needed to improve adherence to management, quality of life, and health outcomes.

This more complex approach to managing chronic disease has been termed "patient-centred care", sometimes abbreviated PCC.[1,2] The "PC" in this abbreviation does not just stand, as some may think, for "politically correct"; this type of care must evolve to become part of the way clinicians think, just as "evidence-based" thinking has now become commonplace. Like many apparently new ideas, many of the concepts central to patient-centred care have been debated before. For example, innovative approaches to improving doctor–patient communication were suggested by authors such as Balint five decades ago.[3] A related development was that of the "patient education approach" to chronic disease, which grew out of the self-care movement of the 1970s and, in concert with increasing theoretical evidence about behaviour change, led to codified principles of collaborative care in the 1980s.[4-6] A decade later, the era of evidence-based care spawned numerous guidelines and protocols for managing chronic disease, which were often difficult to translate into everyday practice. More recent drivers of patient-centred care include economic constraints on healthcare, reduced hospital stays, increases in shared care and a broadened community base for chronic disease management.

Implicit in all innovations is the concept that some doctors will adopt them, others will think about them, and others ignore them as long as possible. Innovations in the public sector are more difficult to market than industry-developed pharmacological agents, which are heavily promoted by the private sector, using multiple media, numerous educational channels and marketing modes to influence clinician behaviour. Ideas such as patient-centred care may be perceived as more difficult to implement and disseminate, and are less clearly related to immediate health gain. We describe here the rationale and methods of patient-centred care, using the examples of diabetes and asthma.

University of New South Wales, Sydney, NSW.

Adrian E Bauman, MPH, PhD, FAFPHM, Professor of Public Health and Epidemiology; and Director, Epidemiology Unit, South Western Sydney Area Health Service, Sydney, NSW; **H John Fardy,** DRCOG, FRACGP, GradCertPH, Senior Lecturer; and Chair, General Practitioners' Asthma Group, National Asthma Council Australia, Melbourne, VIC; **Peter G Harris,** FRACGP, Senior Lecturer, Curriculum Unit, Faculty of Medicine.

Reprints will not be available from the authors. Correspondence: Professor Adrian E Bauman, Epidemiology Unit, Hugh Jardine Building, Locked Bag 7017, Liverpool BC, NSW 1871. a.bauman@unsw.edu.au

Principles of patient-centred care

Patient-centred care has various definitions, but three elements are important:

- communication with patients;
- partnerships; and
- a focus beyond specific conditions, on health promotion and healthy lifestyles.[7]

This type of care requires a thorough explanation of disease to patients and exploration of their feelings, beliefs and expectations (patient "affect and cognition").[8] Management is influenced by these cognitions, patients' social and physical environments and access to affordable local support services, as well as clinical guidelines. There is also a need for increased teamwork, especially with early-discharge schemes, ageing populations, and myriad management protocols. Box 1 summarises some of the principles of managing chronic illness, using aspects of behaviour change theory.

The key to patient-centred care is not only to construct "more expert" patients, but to develop common ground with them for integrated management.[9] The goal is to form a partnership with patients, allowing them to express their individual problems, fears and frustrations with having chronic disease.[10] Some patients will require ongoing support, while others will develop their own coping and acute management strategies, but all should have the autonomy within the clinician–patient interaction to contribute as

1: Principles and examples of patient-centred care

Explore patient "cognitions" (what they think, believe and expect, and their confidence about their disease management).

- Perceptions of disease seriousness or expectations of outcome may influence long-term adherence to management; if patients are convinced that management will improve quality of life, adherence will be better.
- Confidence in performing a procedure will strongly influence whether it is performed regularly (eg, monitoring of peak flows in asthma or blood sugar levels in diabetes).

Explore the social supports, social and family influences and physical environment in which people live, which may influence their health and illness.

- For asthma, are there smokers in the patient's usual environment? For diabetes, what is the patient's access to healthy food choices or physical activity opportunities at home or at work? How does their family support the behaviour changes needed?

Apply the principles of behaviour change: discuss the disease management plan, individualise patient education, and plan for change to occur in stages.

- Negotiate an agreed individualised written disease management plan, including specific strategies for acute symptomatic episodes; find common ground for planning ongoing management (patient and doctor should agree on actions to be taken[9]).
- Tailor education over several consultations (behaviour change is a gradual process); set specific and achievable goals to work at each week or month, aiming towards long-term maintenance of the desired self-management behaviours.
- Plan for follow-up for reinforcement and disease monitoring.

Work with teams of healthcare providers, community agencies and support groups.

- Work as part of a community team and across disciplines (eg, with local asthma educators, local diabetes centres, home-visiting occupational therapists, and support groups).
- Use stepped care, referring to increasingly specialised services as needed (endocrinologists, podiatrists, community nurses).
- (Ideally) share access to updated clinical information across hospital, general practice and community environments to monitor outcomes.

* Adapted from behaviour change theory, especially social cognitive theory.[6]

much as they feel comfortable with to decision-making.[8,11] This comfort will vary between individuals, and with cultural background and age.

Patient autonomy can be a two-edged sword. Occasionally, a fully informed and empowered patient may decide to take risks or not to adhere to management guidelines. This concept of "fully informed choice"[12] may sometimes frustrate the clinician. Nonetheless, patient-centred partnerships are still warranted and will result in a net population health benefit.

2: Hypothetical scenario: an adolescent with asthma

Presentation

Jack, a 14-year-old, presents to a general practitioner with an upper respiratory tract infection, accompanied by his mother. He has persistent symptoms of poorly controlled asthma (most prominent when playing soccer) despite being prescribed appropriate doses of inhaled corticosteroid. His peak expiratory flow rate is now around 70% of his previous best.

Worst-case scenario

At consultation: Jack seems to be an "unwilling visitor" who says little, while his mother does most of the talking. The GP does not address Jack directly, nor ask permission to speak with him alone for a few minutes. There is no opportunity for Jack to ask questions nor any enquiry as to what he thinks about his asthma, how it affects him, and whether he feels he can manage it.

His inhaler technique is not reviewed by direct observation.

His father continues to smoke at home.

GP's closing statement: "You must take your medicines as I have said otherwise you will end up in hospital where you might die."

A month later: GP receives a hospital discharge summary for Jack after a recent admission for asthma exacerbation.

Better scenario using patient-centred care

At consultation: Jack is the centre of the consultation, and his mother is asked to leave for a period.

All questions are directed to Jack in an "adolescent-friendly way" (eg, "What do you think about your asthma?" "What would improve for you if you could better control your asthma?" "Many people your age find that . . . [eg, their ability to play sport] is better when asthma is under control. Would that be good for you?")

The GP also asks about smoking, telling Jack he knows that "many adolescents with asthma smoke".

Lung function tests are performed, and response to a bronchodilator is demonstrated. Inhaler and peak flow meter techniques are observed.

A written management (action) plan is negotiated and agreed.

A follow-up appointment date is made for Jack to review and modify the management plan.

Jack is referred to a specialised asthma education program for adolescents (eg, the AAA [Adolescent Asthma Action] program[27]).

An appointment is made for Jack's father to visit the GP to talk about smoking cessation strategies or at least restricting where he smokes at home.

A month later: Jack presents alone for follow-up and reports he is playing regular soccer without restriction.

Teaching points

- Management of chronic disease in adolescents should take account of adolescents' need for autonomy; their beliefs and expectations should be explored in a non-judgemental manner, and an opportunity provided for communication without their parents present.
- Social and family influences should be sought and addressed (eg, smoking by people with asthma or in their environment).
- Asthma management plans, especially written and agreed plans with review of how well they are working, are central.

Evidence base for patient-centred care

There is some evidence that patient-centred approaches can increase patient satisfaction, engagement and task orientation, reduce anxiety and improve quality of life, as well as increase doctor satisfaction.[8,9,11] Outcomes such as these have also been shown in adults with diabetes undergoing patient-centred interventions,[13,14] and can be produced without lengthening consultations, especially if a team approach to management (involving doctors and other healthcare professionals) is developed. There is also some evidence that patient-centred care is more efficient, even resulting in fewer diagnostic tests and unnecessary referrals.[8]

3: Hypothetical scenario: an adult with diabetes

Presentation

A 55-year-old woman, Vandana, presents for a repeat prescription of antihypertensive medication. She is from India and has lived in Australia for 15 years. She is overweight, but does not smoke or drink alcohol. She is taking an angiotensin-converting enzyme inhibitor and lipid-lowering agent. When questioned about othel;r illness, she says that a locum GP in another practice recently told her she has mild diabetes not requiring treatment. Her blood pressure is 170/95, and glycometer reading is 12.0 mmol/L.

Worst-case scenario

GP: You may have diabetes, and you also have a number of risk factors here. Combined with your hypertension this makes your risk very great for vascular events. You must lose at least 10 kg of weight as soon as possible, get plenty of exercise and avoid sugar. I will order blood tests (fasting blood glucose and cholesterol) and increase your blood pressure medication.

Patient: Yes, of course, you're the doctor, so tell me what to do.

GP: It is really important that you control your blood sugar levels — the consequences could otherwise be serious.

Three years later: The patient has given up work and is housebound with a foot ulcer and other peripheral vascular complications. Her blood pressure remains unstable and elevated, and she has angina.

Better scenario using patient-centred care

GP: Both your blood sugar and blood pressure are high today. Have you taken your blood pressure tablets today?

Patient: Well, doctor, my husband is also on medications, and it is so expensive. Nothing seems to happen if I miss a few blood pressure tablets, so I thought I would get them after my next pay.

GP: Do you know about the prescription safety net? (Explains.) Here's your blood pressure script. Now tell me about your diet.

Patient: I try to stick to a diet doctor, but I cook for my husband and sons, and they eat big meals. We also have many guests and I have to eat with them when they visit.

GP: Your blood sugar is high, so you may have early diabetes. (Discusses diabetes, and asks the patient about her perceptions, fears and community beliefs about "people with diabetes".) It is important that we learn about your diabetes and help you look after it. Let's make an appointment for you to see the Diabetes Educator at the local Diabetes Centre this week. They will help you work out how to eat well and show you how to look after your blood sugar.

Patient: I would really like to lose some weight, but I have not been able to. You are the doctor, so tell me what to do.

GP: Perhaps we should set a small target for weight loss for the first 6 weeks. Diet is important, but it is also good if you can increase your daily physical activity. Can you keep a list of all your daily activity, even walking from the bus stop, for the next week? (Gives patient a physical activity diary and a pedometer and explains its use.)

Patient: I will try doctor. It is not easy, you know.

GP: Let's talk about it more next week. You can let me know how you went at the Diabetes Centre. When we meet, we should both try to work out how to help you with your weight and diabetes. Also, there is an organisation called Diabetes Australia that provides lots of useful support for people with diabetes.

Three years later: The patient has a small but sustained weight loss (4 kg) and is active for half an hour most days with the local walking group; she remains at work. Her blood pressure is mostly under 140/90.

Teaching points

- Patient beliefs about the disease and cultural issues should be considered, such as expectations of medical omniscience.
- Poor adherence may be due to social, physical and socioeconomic issues; each needs to be explored.
- Key behavioural strategies include a written plan for behaviour change, reinforcement and follow-up.
- Community links to ancillary community services and support organisations (eg, Diabetes Australia) are important.

Evidence also supports individual components of patient-centred care, such as self-management training. Cochrane systematic reviews have shown that this training has clear benefits for adults with diabetes.[15] Diabetes management is made challenging by the need for multiple behavioural changes, as well as multiple psychological adjustments. Nonetheless, tight glycaemic control is now considered worthwhile, and results in fewer micro- and macrovascular complications.[16] Furthermore, high-risk groups can lower their risk of developing diabetes more effectively by lifestyle changes than by preventive use of metformin.[17] The Cochrane review of diabetes management assessed 27 controlled trials, and results suggested that improved outcomes resulted from patient-oriented interventions, which included health-system-wide team approaches, follow-up visits, and a "patient education component".[15] Patient education programs that are integrated into patient-centred care are likely to be even more effective than programs delivered independently of primary-care professionals.

Comprehensive asthma self-management programs that use the approaches outlined in Box 1 have also been shown to reduce hospital attendances and admissions, asthma symptoms and time off work or school.[18] Information-only asthma education (provision of a video, pamphlet or guide alone) may be ineffective.[19] This principle generalises to other areas of patient-centred care — simply providing information has been recognised as ineffective for decades, although single-shot resources are still produced as "magic bullet" approaches to chronic disease.[20] It is time to turn off the tap of disease information brochures and leaflets, other than those integrated with more systematic and comprehensive patient-centred approaches.

There is also good evidence for patient-centred care having a favourable impact on other chronic health problems, including chronic musculoskeletal conditions,[6,21] as well as some evidence for it improving management of hypertension.[22] The principles in Box 1 are likely to be generic to collaborative management and behaviour change across any of these conditions.[5]

Across the prevention continuum

Patient-centred care is also a component of preventive care. For primary prevention of disease, patients should be given regular brief advice about reducing risk factors, such as smoking and physical inactivity, where feasible, in the way they have regular blood pressure measurement. This advice may be brief and delivered by practitioners themselves,[23,24]

or more extensive and delivered by practice nurses or teams of other professionals.[25] For secondary prevention, or screening of those at high risk, reminder systems for mammography screening, and to a certain extent Pap smears,[26] are useful vehicles for prevention-oriented partnerships with patients.

Much patient-centred care needs to be at the level of tertiary prevention, to reduce morbidity among those who already have chronic and complex conditions. Hypothetical examples contrasting extreme "worst case" scenarios with better scenarios using patient-centred care are shown in Box 2 and Box 3.

A recent federal government initiative, the Asthma 3+ Visit Plan developed by the National Asthma Council, gives GPs and patients the funded time to spend on necessary areas of management.[28,29] It mandates a series of visits, giving the opportunity to negotiate an agreed management plan so that both patients and GPs can be more confident of their commitment to longer-term management.

Conclusion

Patient-centred care is an important and evidence-based concept for improving health outcomes for people with chronic disease in primary-care practice. The concept is still evolving and is implemented in different ways for each patient.

For patient-centred care to become standard, four issues need to be addressed:

- The healthcare system needs to recognise patient-centred care, to invest in the community teams and professionals required, and to support its delivery in primary care.[1] This will involve re-orienting and re-investing some of the real savings from decreased hospital admissions and shorter hospital stay for patients with chronic disease.
- Medical student training and values need to focus more on patient-centred care; new entry criteria to medical courses and new curricula are cognisant of this approach.
- In addition to linking GPs to community teams, the notion of patient-centred care could also become a greater part of secondary and tertiary specialised medical practice.
- Patient-centred care is more than just empathic interviewing of patients, it is about re-organising healthcare systems to maximise the partnerships of patients and doctors in managing chronic disease.[1]

This is a challenge, because real innovation and change require political commitment, which is sometimes slow to be implemented in health services, even though the evidence for patient-centred approaches to chronic disease management is already strong.

Competing interests

None identified.

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- For asthma, are there smokers in the patient's usual environment? For diabetes, what is the patient's access to healthy food choices or physical activity opportunities at home or at work? How does their family support the behaviour changes needed?

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A 55-year-old woman, Vandana, presents for a repeat prescription of antihypertensive medication. She is from India and has lived in Australia for 15 years. She is overweight, but does not smoke or drink alcohol. She is taking an angiotensin-converting enzyme inhibitor and lipid-lowering agent. When questioned about othel;r illness, she says that a locum GP in another practice recently told her she has mild diabetes not requiring treatment. Her blood pressure is 170/95, and glycometer reading is 12.0 mmol/L.

Worst-case scenario

GP: You may have diabetes, and you also have a number of risk factors here. Combined with your hypertension this makes your risk very great for vascular events. You must lose at least 10 kg of weight as soon as possible, get plenty of exercise and avoid sugar. I will order blood tests (fasting blood glucose and cholesterol) and increase your blood pressure medication.

Patient: Yes, of course, you're the doctor, so tell me what to do.

GP: It is really important that you control your blood sugar levels — the consequences could otherwise be serious.

Three years later: The patient has given up work and is housebound with a foot ulcer and other peripheral vascular complications. Her blood pressure remains unstable and elevated, and she has angina.

Better scenario using patient-centred care

GP: Both your blood sugar and blood pressure are high today. Have you taken your blood pressure tablets today?

Patient: Well, doctor, my husband is also on medications, and it is so expensive. Nothing seems to happen if I miss a few blood pressure tablets, so I thought I would get them after my next pay.

GP: Do you know about the prescription safety net? (Explains.) Here's your blood pressure script. Now tell me about your diet.

Patient: I try to stick to a diet doctor, but I cook for my husband and sons, and they eat big meals. We also have many guests and I have to eat with them when they visit.

GP: Your blood sugar is high, so you may have early diabetes. (Discusses diabetes, and asks the patient about her perceptions, fears and community beliefs about "people with diabetes".) It is important that we learn about your diabetes and help you look after it. Let's make an appointment for you to see the Diabetes Educator at the local Diabetes Centre this week. They will help you work out how to eat well and show you how to look after your blood sugar.

Patient: I would really like to lose some weight, but I have not been able to. You are the doctor, so tell me what to do.

GP: Perhaps we should set a small target for weight loss for the first 6 weeks. Diet is important, but it is also good if you can increase your daily physical activity. Can you keep a list of all your daily activity, even walking from the bus stop, for the next week? (Gives patient a physical activity diary and a pedometer and explains its use.)

Patient: I will try doctor. It is not easy, you know.

GP: Let's talk about it more next week. You can let me know how you went at the Diabetes Centre. When we meet, we should both try to work out how to help you with your weight and diabetes. Also, there is an organisation called Diabetes Australia that provides lots of useful support for people with diabetes.

Three years later: The patient has a small but sustained weight loss (4 kg) and is active for half an hour most days with the local walking group; she remains at work. Her blood pressure is mostly under 140/90.

Teaching points

- Patient beliefs about the disease and cultural issues should be considered, such as expectations of medical omniscience.
- Poor adherence may be due to social, physical and socioeconomic issues; each needs to be explored.
- Key behavioural strategies include a written plan for behaviour change, reinforcement and follow-up.
- Community links to ancillary community services and support organisations (eg, Diabetes Australia) are important.

Evidence also supports individual components of patient-centred care, such as self-management training. Cochrane systematic reviews have shown that this training has clear benefits for adults with diabetes.[15] Diabetes management is made challenging by the need for multiple behavioural changes, as well as multiple psychological adjustments. Nonetheless, tight glycaemic control is now considered worthwhile, and results in fewer micro- and macrovascular complications.[16] Furthermore, high-risk groups can lower their risk of developing diabetes more effectively by lifestyle changes than by preventive use of metformin.[17] The Cochrane review of diabetes management assessed 27 controlled trials, and results suggested that improved outcomes resulted from patient-oriented interventions, which included health-system-wide team approaches, follow-up visits, and a "patient education component".[15] Patient education programs that are integrated into patient-centred care are likely to be even more effective than programs delivered independently of primary-care professionals.

Comprehensive asthma self-management programs that use the approaches outlined in Box 1 have also been shown to reduce hospital attendances and admissions, asthma symptoms and time off work or school.[18] Information-only asthma education (provision of a video, pamphlet or guide alone) may be ineffective.[19] This principle generalises to other areas of patient-centred care — simply providing information has been recognised as ineffective for decades, although single-shot resources are still produced as "magic bullet" approaches to chronic disease.[20] It is time to turn off the tap of disease information brochures and leaflets, other than those integrated with more systematic and comprehensive patient-centred approaches.

There is also good evidence for patient-centred care having a favourable impact on other chronic health problems, including chronic musculoskeletal conditions,[6,21] as well as some evidence for it improving management of hypertension.[22] The principles in Box 1 are likely to be generic to collaborative management and behaviour change across any of these conditions.[5]

Across the prevention continuum

Patient-centred care is also a component of preventive care. For primary prevention of disease, patients should be given regular brief advice about reducing risk factors, such as smoking and physical inactivity, where feasible, in the way they have regular blood pressure measurement. This advice may be brief and delivered by practitioners themselves,[23,24]

or more extensive and delivered by practice nurses or teams of other professionals.[25] For secondary prevention, or screening of those at high risk, reminder systems for mammography screening, and to a certain extent Pap smears,[26] are useful vehicles for prevention-oriented partnerships with patients.

Much patient-centred care needs to be at the level of tertiary prevention, to reduce morbidity among those who already have chronic and complex conditions. Hypothetical examples contrasting extreme "worst case" scenarios with better scenarios using patient-centred care are shown in Box 2 and Box 3.

A recent federal government initiative, the Asthma 3+ Visit Plan developed by the National Asthma Council, gives GPs and patients the funded time to spend on necessary areas of management.[28,29] It mandates a series of visits, giving the opportunity to negotiate an agreed management plan so that both patients and GPs can be more confident of their commitment to longer-term management.

Conclusion

Patient-centred care is an important and evidence-based concept for improving health outcomes for people with chronic disease in primary-care practice. The concept is still evolving and is implemented in different ways for each patient.

For patient-centred care to become standard, four issues need to be addressed:

- The healthcare system needs to recognise patient-centred care, to invest in the community teams and professionals required, and to support its delivery in primary care.[1] This will involve re-orienting and re-investing some of the real savings from decreased hospital admissions and shorter hospital stay for patients with chronic disease.
- Medical student training and values need to focus more on patient-centred care; new entry criteria to medical courses and new curricula are cognisant of this approach.
- In addition to linking GPs to community teams, the notion of patient-centred care could also become a greater part of secondary and tertiary specialised medical practice.
- Patient-centred care is more than just empathic interviewing of patients, it is about re-organising healthcare systems to maximise the partnerships of patients and doctors in managing chronic disease.[1]

This is a challenge, because real innovation and change require political commitment, which is sometimes slow to be implemented in health services, even though the evidence for patient-centred approaches to chronic disease management is already strong.

Competing interests

None identified.

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