Time to learn: understanding patient-centred care

Rinchen Pelzang

Abstract

This article is a literature review of the definition, models and methods of implementation of patient-centred care (PCC). Modern healthcare systems are rapidly changing to adopt a more patient-centred approach to care. However, the implementation of PCC can be hampered by the lack of a clear definition and methods of measurement. It is increasingly important for healthcare providers to understand the core elements of PCC. This article examines the literature to carry out a concept analysis of PCC, including definition, concepts and theoretical perspectives.

Key Words: Patient-centred care ■ Holistic care ■ Nurse education ■ Healthcare models

Patient-centred care (PCC) is a widely used model in the modern healthcare system. The movement towards PCC is significant in the United States, United Kingdom, Europe and Asia, and developing patient-centred services is a major theme of healthcare systems around the world. However, there are difficulties with the concept, especially at the level of implementation (Davies, 2007: p39). The implementation of PCC has been hampered by the lack of a clear definition and method of measurement (Robinson et al, 2008). In an attempt to define PCC, a literature review was conducted to identify the fundamental characteristics of PCC to clarify its definitions and concepts. Electronic data sources such as Medline, CINAHL, ProQuest, and Google Scholar were used to search the literature. The key words used during the literature search were patient-centred care, patient-focused care, person-centred care, nurse–patient relationship, and nurse–patient communication. The review attempted to answer the following questions:

- What is PCC?
- What are the benefits of PCC?
- What are the factors contributing to PCC?
- What are the barriers to PCC?

The key aims of this article are to describe our current understanding of PCC; compare existing models; discuss the relative benefits and disadvantages of PCC; describe key skills required to practise PCC; summarize key elements required to implement a PCC approach and barriers to its implementation.

Rinchen Pelzang is Registered Nurse Midwife at Jigme Dorji Wangchuk National Referral Hospital, Ministry of Health, Royal Government of Bhutan, Thimphu, Bhutan

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What is patient-centred care?

PCC is described as 'treating the patient as a unique individual' (Redman, 2004: p11). It is a standard of practice that demonstrates a respect for the patient, as a person (Binnie and Titchen, 1999; Shaller, 2007). It is very much about considering the patient's point of view and circumstances in the decision-making process, and goes well beyond simply setting goals with the patient (Ponte et al, 2003).

Patient-centredness also refers to a style of doctor–patient encounter characterized by responsiveness to patient needs and preferences, using the patient's informed wishes to guide activity, interaction and information-giving, and shared decision-making (Rogers et al, 2005). It is a way of viewing health and illness that affects a person's general well-being and an attempt to empower the patient by expanding his or her role in their health care. Making the patient more informed, and providing reassurance, support, comfort, acceptance, legitimacy and confidence are the basic functions of PCC (Fulford et al, 1996). The impact of the goals of PCC has a direct logical link with promoting healing and reducing injury and suffering (Nelson and Gordon, 2006).

The underlying philosophy of PCC is that the carer needs to understand the patient as a person rather than as a cluster of diseases (Epstein, 2000). PCC delivers care to the patient through a range of activities including consideration of the patient's beliefs and values, engagement, having a sympathetic presence, and providing for physical and emotional needs (McCormack and McCane, 2006). Working with patients' beliefs and values strengthens one of the important principles of PCC. This is closely related to shared decision-making and facilitating patient participation through giving information and integrating newly formed perspectives into care activities (Stewart, 2001). PCC assumes that the patients are qualified to decide their own needs and expectations, and that they are able to make decisions and choices about what they need and want (Lutz and Bowers, 2000). The provision of PCC is to educate patients of appropriate health advice so that they can make informed decisions. Coulter (2002a) defines PCC as:

> **'Health care that meets and responds to patients' wants, needs and preferences and where patients are autonomous and able to decide for themselves.'**

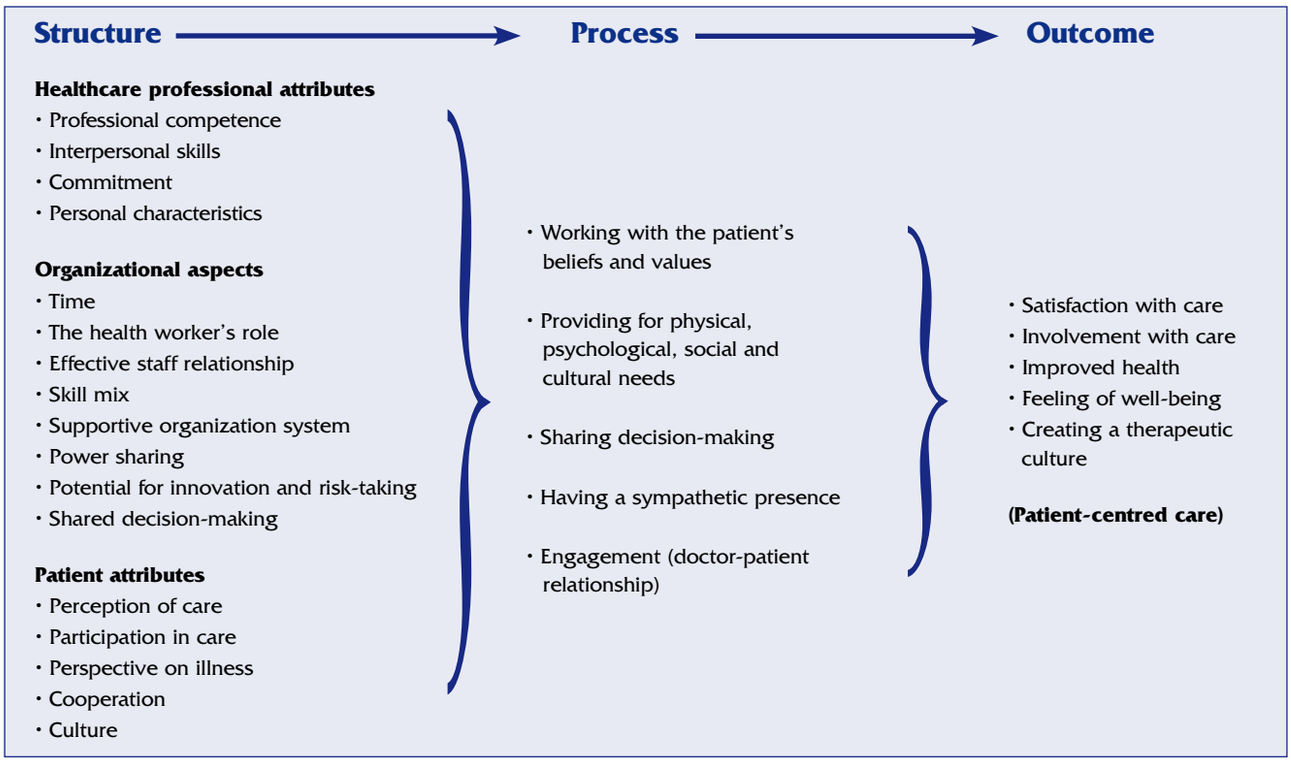

Figure 1. A system theory of patient-centred care (McCormack and McCane, 2006)

Through the literature review, the fundamental characteristics of PCC were identified as the individualization of patient care, and the involvement of patient in the care through information and shared decision-making (Robinson et al, 2008). To acknowledge and value each patient's own way of perceiving and experiencing what is happening to them is considered to be an important aim of PCC. The role of the patient-centred health professional is to be there, offering personal support and practical expertise, facilitating the patient to follow the path of their own choosing, in their own way (McCormack and McCane, 2006). Either explicitly or implicitly, PCC is referred to as meeting the patient's needs in health care (Lutz and Bowers, 2000). The attributes of healthcare practice that is patient-centred are represented in the system theory format shown in *Figure 1*.

Models of patient-centred care

The development of the concept of patient centredness emerged from the limitations in the conventional 'biomedical model', where illnesses are taken to indicate the existence of disease processes (Mead and Bower, 2000). PCC involves the patient in all aspects of their care and moves away from medical practice with minimal communication towards open communication (Shaller, 2007). The concept of PCC places the patients at the centre of the healthcare system and recognizes the patient as a whole person with physical, psychological and social needs (Flarey, 1995; Pence, 1997). Considering the patient as a whole person and caring with respect is seen as a basic aspect of PCC. PCC is considered from two approaches: a systems model and a process model.

A systems model consists of a hierarchy of constructs which create a patient-centred environment (*Figure 2*), which is considered to be central to the PCC framework (Robinson, 1991). Emphasis is given to meeting individualized patient care needs by organizing staff and services around the needs of the patient (Flarey, 1995; Coulter, 2002b; Ponte et al, 2003; Shaller, 2007).

The process model is an approach that consciously adopts the patient's perspective, consisting of seven dimensions (*Box 1*) (Gerteis et al, 1993). It describes a range of activities, including: consideration of the patient's beliefs, values and expressed needs; coordinating and integrating the care; informing, communicating and educating the patient on treatment and care; providing physical comfort and emotional support; involving patients and families in decision-making; and ensuring transition and continuity of patient care.

Essentially, the systems model emphasizes the creation of a patient-centred environment in order to successfully implement PCC in the healthcare system, while the process model describes a range of activities essential for PCC (Abdellah et al, 1973; Brown et al, 2006).

Advantages of the patient-centred care model

The patient-centred care model places the patient at the centre of the delivery of care, and redirects activities so that the right job is performed effectively by the right person at the right time (Pence, 1997). The literature indicates that PCC improves continuity of care and integration of health professionals collaborating on behalf of their patients, by minimizing the movement of patients through the hospital, providing autonomy to patients, and empowering staff members to plan and execute their work in ways that are most responsive to patient needs (Lathrop et al, 1991; Robinson, 1991; Frisch et al, 2000). PCC is also known

to respond precisely to each patient's needs, wants and preferences (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). It provides patients with abundant opportunities to be informed and involved in care decision-making. Furthermore, PCC delivers more holistic care; enhances communication skills between relatives, patients and healthcare providers; shifts emphasis from body care to total care; facilitates a team approach; and facilitates reflection, learning and sharing of skills and abilities among health professionals (Ellis, 1999).

Having discussed its various advantages, PCC is not without any limitations or disadvantages. The core disadvantages of PCC include:

- a lack of clear descriptions of measurable behaviours and patient outcomes (Robinson et al, 2008; Nelson and Gordon, 2006)
- the requirement for structural changes at organizational and practice level, which can be difficult (Robinson, 1991; Brown et al, 2006)
- the need for more time and human resources to care for patients (Buerhaus et al, 2005).

Box 1. Dimensions of PCC (Gerteis et al, 1993)

1) Respect for patients' values, preferences and expressed needs
- Accepting patient as a person
- Involving patients in care decision-making
- Listening and considering patients' needs
- Maintaining confidentiality to protect patients' information

2) Coordination and integration of care
- Working in multidisciplinary approach
- Coordinating and integrating clinical care; ancillary and support services; and 'frontline' patient care
- Involving patient and family in planning, decision-making and quality improvement processes at organizational level

3) Information, communication and education
- Providing accurate and understandable information about treatment, care and interventions
- Listening actively to the patient and family
- Provide therapeutic touching and talking when necessary

4) Physical comfort
- Promoting comfortable and supportive hospital environment
- Providing timely, tailored, and expert management of symptoms
- Providing basic health care that supports and maintains normal body functions

5) Emotional support and alleviation of fear and anxiety
- Listening to patient with undivided attention
- Providing clear, timely and meaningful information regarding the illness
- Caring with empathy

6) Involvement of family and friends
- Providing with enough information regarding the patient's illness
- Respecting and acknowledging the family and friends' support in patient care
- Providing supportive environment

7) Transition and continuity of care
- Involving patient and family in discharge planning
- Providing clear information and education on dangers signs to watch, whom to contact if there are questions, what to do in emergency, how to handle treatments, dressing changes, and medications
- Referring patient to appropriate health centre with clear discharge instructions

Knowledge and skills required in patient-centred care

The literature indicates that the one of the most important jobs of the health professional in delivering PCC is to put the patient in the right environment to ensure optimal recovery. The ability to care for the patient as a whole person is considered the essence of good healthcare practice in PCC (Kitson, 1999). Determining, planning and prioritizing the care required by the patient and family are the main activities through which this can be achieved (Broom, 2007). The ability to focus on significant events, conditions or situations affecting the patient are other important skills which enable the health professional to deliver personalized care. From the literature, it is evident that health professionals must have good knowledge of clinical practice, coupled with skills in data gathering, clinical reporting, procedures, communication (Lipkin et al, 1984; Roter and Hall, 2004; Tongue et al, 2005; Beach et al, 2006), and relationship development with patients and families, and other health professionals (Binnie and Titchen, 1999; McCormack and Corner, 2003; O'Halloran et al, 2005; Price, 2006; Booth and McBride, 2007) (*Box 2*).

Factors contributing to patient-centred care

Building a culture of patient-centredness requires major changes, including learning how to talk and listen to patients, adopting new ways of providing care, and overcoming fears or learned behaviours (Holmes et al, 2003). Shaller (2007) identified the following seven key factors that contribute to achieving PCC at organizational level.

1) Leadership

The single most important factor contributing to PCC, whether in the hospital or ambulatory care setting, is the commitment and engagement of senior leadership at the level of Chief Executive Officer (CEO) and Board of Directors (Shaller, 2007). It means that the CEO and Board of Directors must be sufficiently committed and engaged to unify and sustain the organization in a common mission. The organizational transformation required to actually achieve the sustained delivery of PCC will not happen without the support and participation of top leadership.

2) A clearly communicated strategic vision

The development of a clear vision and strategic plan for how PCC will fit into the priorities and processes of the organization on a daily, operational basis with exceptional, committed leadership in place is considered essential to attaining PCC (Shaller, 2007). Shaller emphasizes the importance of articulating a vision and mission statement with clear, simple elements that can be easily repeated and embedded in routine activities that all staff members carry out. Establishing, communicating and reinforcing realistic

visions and outcomes throughout the organization is critical to success (Flarey, 1995).

3) Involvement of patients and families

PCC means treating patients as partners, involving them in planning their health care, and encouraging them to take responsibility for their own health (Lowes, 1998). It is important to involve the patient and their family, who can provide vital support and information throughout the care process. Patients and their families should be involved:

- at the point of care delivery, where they can contribute to the process of gathering information
- at the clinical micro system level, where they should participate in the process of healthcare planning
- at the local, state and national policy level, where the perspectives of patients and families are critical in the delivery of quality care (Shaller, 2007).

4) Supportive work environment: care for the caregivers

To make a healthcare system patient-centred, we must create and nurture an environment in which the organization's most important asset—its workforce—is valued and treated with same level of dignity and respect that the organization expects its employee to provide to patients and families (Shaller, 2007). Shaller (2007) acknowledges the importance of hiring, training, evaluating, compensating and supporting a workforce committed to PCC. In order to achieve this commitment and engagement, it is important to involve employees directly in the design and implementation of patient-centred processes. Shaller argued that the healthcare organization should be 'human-centred' not just patient-centred, where all the stakeholders, including healthcare managers and other front-line staff, are engaged in creating effective and responsive systems of care.

5) Systematic measurement and feedback

Shaller (2007) maintains that the major factor contributing to PCC is the presence of a robust listening capacity, that enables an organization to systematically measure and monitor its performance based on feedback from service users. There should be a system to continuously monitor the impact of specific interventions and change strategies in a PCC healthcare system. Evaluations which include multiple measures of performance, such as patient experience surveys, complaints, patient satisfaction measures, and rates of voluntary withdrawal from a practice, are known to improve the quality of patient care through changes to practice.

6) Quality of the built environment

One of the most important factors contributing to PCC is the quality of the physical environment in which care is provided (Shaller, 2007). Shaller argues that the design of a healthcare facility contributes to PCC when it:

- welcomes the patient's family and values human beings over technology
- enables patients to fully participate as partners in their care
- provides flexibility to personalize the care of each patient
- encourages caregivers to be responsive to patients

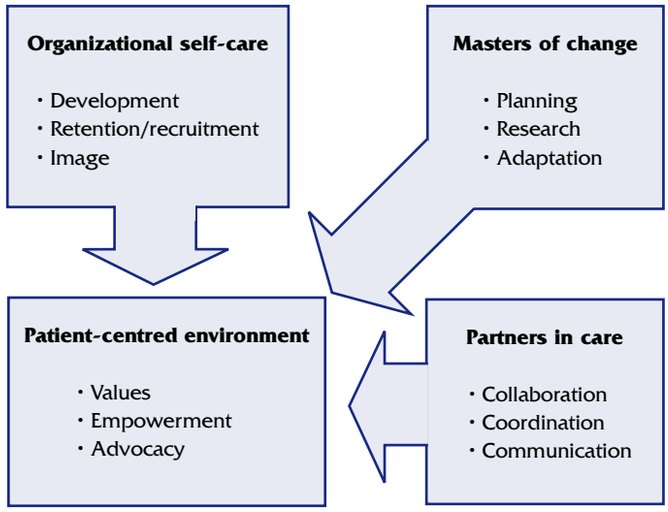

Figure 2. Systems model of PCC (Flarey, 1995)

- fosters a connection to nature.

7) Supportive technology

Supportive technology, such as health information technology (HIT) encourages patients and families directly in the process of care by facilitating information access and communication with their caregivers (Shaller, 2007). HIT facilitates communication between patients and caregivers by providing access to needed information and decision support tools. HIT can range from simple email communication between patients and caregivers, to more sophisticated patient web portals that enable patients to interact with their caregivers' electronic medical records. Shaller (2007) suggests that HIT applications in patient care have demonstrated an enhancement of nurse–patient partnerships in care.

Barriers to patient-centred care

Although leaders in the health professions have advocated incorporating patient centredness in the education of health professionals, there remain several educational, practice and regulatory barriers to implementing a patient-centred vision. The following are some of the most prominent barriers to PCC.

Lack of clear definition of patient-centred care

The lack of articulation of what PCC involves is a well-recognized problem within health care (Nelson and Gordon, 2006). Patient-centred care is a widely used but poorly understood concept in medical practice (Stewart, 2001). The lack of clarity in the definition itself is a barrier to implementation of PCC (Davies et al, 2007). Failure to define what PCC is and how it works will have major implications for healthcare outcomes.

Inadequate educational emphasis on PCC

PCC needs interprofessional practice, and an organized interprofessional education programme is essential to achieve this. However, there is widespread acknowledgement, particularly in medical education, of an 'informal curriculum', whereby faculty and resident role models

Box 2. Knowledge and skills needed in patient-centred care

Knowledge
Clinical practice
Principles of practice
Clinical problems (disease conditions)

Skills
Data gathering or patient assessment skills
(ability to determine, plan and prioritize the care)
History-taking
Physical examination

Procedural skills
(Ability to follow the principles of procedure)
Preparation
Performance
Attention to patient comfort and dignity

Communication skills
(Ability to communicate with patient, family and professionals)
Attentive listening
Questioning
Education and information-giving

Relationship skills
(Ability to develop and maintain the helping or professional relationship)
Empathy
Congruence
Genuineness
Mutual respect
Courtesy
Positive regard
Joint participation

Reporting and recording skills
(Ability to maintain and communicate the details of patient clearly, completely and concisely)
Case presentation
Writing notes, history and complaints

often have a greater impact on trainee behaviour than organized educational interventions. In nursing, the failure to recognize nurse–patient communication as an essential component of nursing care is the greatest barrier to effective communication.

Lack of coordination, collaboration and continuity of care

Glick and Moore (2001) described a 'discontinuous' healthcare system, in which patients are quickly handed over to personnel in new venues of care. In such systems, healthcare providers develop a narrow, task-specific view of the patient's illness and cannot view the patient as a whole person. This encourages the creation of role divisions, which causes the fragmentation of care. The division of roles and the fragmentation of care limits the opportunities for health professionals to see a patient's progress, and gives them only limited exposure to the complete course of a patient's illness.

Shortage of staff

Overwork and staff shortages are the main barriers to PCC observed in the practical setting (Pelzang et al, 2010). Dunn (2003) points out that lack of time, motivation and wisdom act as barriers to PCC. Owing to time and staff constraints, health professionals often do not sit with their patients, and when they do, often listen hurriedly to their concerns (Buerhaus et al, 2005). A shortage of health staff leads to rituals and routines of practice which impede the development of PCC in hospitals (Kelly, 2007). Even in healthcare practices where PCC is valued, the demands of caring for many patients at a time can undermine professionals' ability to provide physical and emotional support, and respect for their patients' preferences (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001).

Absence of good teaching models and curricula on patient-centred care

Lewin et al (2001) stress that some educational methods have been shown to lead to increased patient-centredness, but these observations are scattered and not entirely replicable across the disciplines. Most of the aspects of PCC, other than communication skills, are not taught as part of the curricula. Levinson and Roter (1993) maintain that there are not enough continuing education programmes available to teach current healthcare providers in aspects of PCC, especially on social and interpersonal aspects.

Dominance of biomedical model in healthcare

In health care, a biomedical model of practice prevails. Patients' reports of illness are taken to indicate the existence of a disease process (Mead and Bower, 2000). A patient can present with a condition related to a larger problem rooted in aspects of their daily life, which are totally ignored. Above all, in the dominant biomedical paradigm, the patient is no longer viewed as a whole person and their needs are not acknowledged.

Cost-effectiveness of PCC

Economic constraints on health care is a recent driver of PCC, and one aim of implementing PCC is to provide better clinical outcomes and lower the cost per case (Stone, 2008).

The evidence on the cost-effectiveness of PCC is not substantial and conclusive, however, it does indicate that PCC provides better clinical outcomes and health cost management (Bezold, 2005; Stone, 2008). Recent studies of the cost effectiveness of a PCC integrated care pathway by Olsson et al (2009) and Reid et al (2009) showed improved patient outcomes and cost-effectiveness, with a 40% reduction in the total cost of treatment. However, the harsh reality of budgetary pressures in terms of educating and recruiting large number of health professionals is reported to be a major issue in implementing PCC in healthcare systems (Coulter, 2002b).

Conclusion

PCC is understood to be a healthcare system which considers patients as a whole person with biological, psychological and social needs. Respect, compassion, concern, shared decision-making and communication are seen as basic elements for PCC. PCC is said to improve the quality of patient care, reduce the cost of care, and increase satisfaction among nurses, physicians and patients by strengthening professional practice and maintaining the values of the patient and healthcare providers.

It is evident that effective PCC requires health professionals to have good knowledge of clinical practice, as well as skills in data gathering, clinical reporting/documentation, procedures, communication, and relationship development with patients their families, and other professionals. However, inadequate emphasis on PCC in education, a lack of coordination and collaboration among health professionals, a shortage of staff, and the dominance of a biomedical model of health care act as barriers to the delivery of PCC. This implies that the implementation of PCC requires a planned and coordinated approach, with sufficient staff, efficient teamwork, and adequate education of healthcare providers. BJN

Conflict of interest: None

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KEY POINTS

- Patient-centred care (PCC) places the patient at the centre of healthcare system
- PCC considers patient as a whole person with physical, psychological and social needs
- Provision of a supportive environment that promotes recovery is recognized as a critical role of the healthcare profession, and health professionals need to have the skills to provide supportive, holistic care
- Implementation of PCC requires adequate and appropriate education on PCC, with a planned and coordinated approach