

# QUALITY IN HEALTH CARE

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## Editorials

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### Developing professional ability to involve patients in their care: pull or push?

The involvement of patients in the decisions about their treatment or care seems an unquestionable advance.<sup>1</sup> There are philosophical and ethical justifications for this.<sup>2</sup> Evidence is also accruing about its benefits—namely, increased satisfaction with care and communication, increased certainty about making the best decision, reduced anxiety levels, and greater adherence to chosen management plans.<sup>3</sup> Some of the practical barriers that limit the greater involvement of patients in clinical practice are also being recognised and addressed,<sup>4</sup> including the wider availability of information to patients, often outside the consultation.<sup>5</sup> Yet patient involvement and informed choices are still not a reality in routine health care. There still appear to be barriers that directly relate to healthcare professionals which must be addressed if patient involvement is indeed to become a wider reality.

Healthcare professionals need to assimilate a number of principles and practices if they are to facilitate patient involvement.<sup>6</sup> Some of these apply more to *global changes in attitudes* and approaches to healthcare provision (“macro” level), and are the fundamental competences which professionals acquire as the platform for their practice.<sup>7</sup> Others relate to their skills in providing care to the hundreds, or perhaps thousands, of patients with whom they interact—that is, the “competences” of practice<sup>7</sup>—and apply to the *process within the consultation* (“micro” level), the way professionals deal with individuals, their needs, concerns, desires, and expectations.

Many of the points raised in this editorial are considered more fully in the supplement on *Engaging Patients in Decisions* which accompanies this issue of *Quality in Health Care*. Free access to the supplement is available on the website at [www.qualityhealthcare.com](http://www.qualityhealthcare.com).

At the “macro” level professionals need to appreciate the dilemmas that exist regarding the goals of modern health care. There is an increased focus on standardisation of health care which aims to reduce unacceptable variations in treatments or investigations offered and “consumed”. In practice, much of the effort towards this depends on guidelines and protocols which are often rigorously developed. The momentum in this direction has increased recently in the UK with the output from the National Institute for Clinical Excellence and the National Service Frameworks (NSF) for ischaemic heart disease, cervical screening, and others shortly to follow (care of the elderly, management of diabetes).

But there is a tension here. The public health efforts of guidelines and NSFs may result in less flexibility in dealing with individual patients. It may therefore limit the scope for informed choices by the consumers—that is, the patients—and, by implication, they will have less true involvement in the decision making in practice. More informed choices by consumers can result in some opting out of treatment or surveillance programmes.<sup>3</sup> We need to recognise that we may not be able to fulfil the requirements of *both* greater involvement and informed choice at the individual level *and* adherence to guidelines and NSFs at the public health or population level.<sup>8</sup> Awareness and acceptance of the issue is an important first step. Professionals need to arrive at a personal view of how they reconcile this dilemma in their own practice, perhaps even choosing whether to pursue the public health *or* the individually focused approach. They must integrate this personal perspective into their approach to delivery of health care for the patients they see. At the moment practitioners are perhaps more aware of the pressure to meet targets in guidelines and NSFs than they are of the pressures from or desires of patients for more involvement, information, and informed choice. Greater awareness of the latter may depend, at least partly, on acquiring experience and skills in involving patients in clinical decision making—the “micro” level issues.

At the micro level professionals need to acquire or enhance their skills in involving consumers in decisions. The competences required to do this are becoming established<sup>9–11</sup> but, as yet, and as in every other area of health care, gaps between competence and performance still need to be addressed. There are developments now which seek to address these needs of professionals by training. The use of simulated patients to work through scenarios in which participants can experience, observe, and discuss new consulting approaches in a “safe” environment appears to hold promise.<sup>6–11–12</sup> They can also gain confidence in using decision support information that might be appropriate for use in the short consultations of general practice.<sup>13</sup> Both professionals and experienced patient simulators can discuss and explore their reactions to the process of these new consulting approaches. By asking participants to review the process for each scenario undertaken, “reflection-on-action” is promoted.<sup>14–15</sup> The ethical issues are also exposed and brought to the forefront for consideration. Participants address how the skills and techniques may apply in their own practice and how they can accommodate the tension between individual and public health goals. These work based experiential learning

approaches engender a sense of ownership of the process and are consistent with educational theory.<sup>16</sup>

However, although these training programmes may help professionals to assimilate the philosophy and skills required for involving patients more in decision making, more is still required. Clearly, professionals need to engage with such training and this is not automatic. Motivation for participation in the training is achieved in some healthcare systems by financial incentives or the requirements of revalidation or re-certification. However, a further stimulus should not be neglected—namely, the expectations of patients and patient advocate groups. At present, in the UK at least, a substantial proportion of consumers do not apparently wish to be involved in making choices about their treatment or care,<sup>17</sup> but evidence is also accruing about the benefits of involvement and decision support.<sup>3</sup> There is therefore justification for continued pressure on professionals from patient advocate groups to promote and expect newer consulting approaches. This may prove to be the most crucial influence. At a wider level, it may also be a case study in making explicit the links between patient expectations, professional development requirements, and training programmes. It may provide a model in which professionals identify their needs for continuing professional development directly from the needs of patients and seek new training opportunities.

A EDWARDS  
G ELWYN

*Department of General Practice, University of Wales College of Medicine, Llanedeyrn Health Centre, Llanedeyrn, Cardiff CF3 7PN, UK  
Edwardsag@cf.ac.uk*

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## Ensuring patients' satisfaction with information about their medicines

*See article on page 135*

Patients crave information. I am writing this while an in-patient at a London teaching hospital, and the need for information is almost palpable. Patients exchange whispered conversations in which they pass on intelligence (or not) about the ward, its staff, and medical procedures. Visiting time is characterised by families getting cross with the patients because they can't answer detailed questions and "should ask the doctor". Nurses are generally amiable but know little about the individual patients. The pharmacist stalks the end of the beds, reading drug charts while avoiding eye contact and failing to introduce him/herself. Doctors parry questions with the deftness of an Olympic fencer, or give a direct answer which, while factually correct, leaves one yearning for context within which to interpret the facts.

While a patient can be dissatisfied yet cured in hospital (because things are done to the patient), in primary care patients generally look after themselves so they need to be willing partners. The importance of the active cooperation of patients is never more clear than in the case of medicines, the mainstay of treatment in primary care. It has been known since Hippocrates' time that patients do not always take their medicines as directed (sic) by the physician. We now divide these people into intentional and unintentional non-adherers, recognising that, although the end point may be the same, the issue of intentionality is crucial. Why should a patient follow medical advice? Anthropologists have taught us about medical pluralism, a term describing the ways in which patients take advice from more than one specialist or individual. The advice

from the doctor is therefore weighed with that of the daughter, the neighbour, the person in the health food shop, and so on. Doctors may believe in science, but that is no reason why patients should.

Patients increasingly require some sort of rationale before following advice. We know that about a third to a half of patients on chronic medication do not follow the advice of their prescribers when it comes to medicine taking. Some of these are doing so unintentionally, perhaps because they cannot remember complicated polypharmacy regimes, and others do so intentionally, perhaps because they have beliefs that medicines are bad, or addictive, or just that the doctor did not understand their problem.<sup>1</sup> The only way we can deal with these problems is to engage with patients and to explain our knowledge and views to their satisfaction. If patients are not satisfied with the amount of information they have received about their medicines, questions remain in their mind and they are more likely to become non-adherent.

How can we know if patients are satisfied with the information they received about their medicines? Help is now at hand in the form of a questionnaire, described by Horne and colleagues in this issue of *Quality in Health Care*.<sup>2</sup> Several questions probe two broad agendas—do patients understand how to take the medicine and what it does, and do they know the risks of taking it? The authors show not just that their instrument (the Satisfaction with Information about Medicines Scale (SIMS)) is reliable, but that it broadly predicts self-reported adherence.