Path to Patient Centred Care

Discussion on the potential benefits of patient centred care and what needs to happen to truly achieve it

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Foreword

There are multiple pathways to enter a career in health care. Our pathways might all differ in some way or another but the reasons for choosing such a career are all based on the same aim, focus and philosophy. We want to contribute towards improving the health outcomes of humankind – to prevent illness, to cure, to support where a cure is not possible and to be there in the final days.

Early on in our careers, in our naivety, it is all about the patient, that person in front of us that at that moment in time needs our help. That is what we trained for. However, as we progress in our careers we soon come to realise that health care takes place within a very complex system. We can easily get caught up in this complexity and forget why we chose a career in health in the first place. When did you last remember why you became a doctor? The health care system faces the same challenge and should constantly remind itself (or be reminded by us) that it is and should be all about the patient.

Patient centred care is a no brainer. Potential benefits for patients include better health outcomes through improved adherence to prescribed treatment, improved recovery, shorter hospital stays, improved psychological adjustments and mental health, fewer medical errors, and improved self-management of chronic illness.

Broadly, it is about having a health system where people receive more individualised and holistic care and are demonstrably equal partners in managing their health. Considering an individual's needs as a whole rather than treating medical problems in isolation, providing flexible care that tailors support according to an individual's personal priorities and needs, and forming collaborative relationships between patients and their doctors are all self-evidently good practice. That it has also been shown to be a cost-efficient way of delivering care makes it doubly more so.

A critical factor for successful patient centred care is the quality of the patient–doctor interaction. When it is good, the quality and safety of health care rise, costs fall, and levels of patient and staff satisfaction increase.

In short, patient centred care ticks many of the boxes for addressing the challenges policymakers around the world are grappling with – not least the cost-savings factor.

So how is the senior medical officer (SMO) workforce in New Zealand placed to develop improved patient centred care, and how are current health policies assisting?

Commonly identified barriers to delivering patient centred care include time constraints, workload, inadequate communication skills, poor patient health literacy, lack of leadership and, for some clinicians, an unwillingness to change. From the SMO workforce perspective, a common factor, directly or indirectly, is time.

Good quality (and often multiple) conversations with service users, about their health and the benefits and risks of their treatment options, requires good quality time. The Choosing Wisely campaign developed by the Council of Medical Colleges provides a framework for the health professional and the patient to discuss the best health choices for that individual. It encourages and supports a partnership approach at the interface between the doctor (the sharp end of the health care system) and patient. Similarly, advanced care planning is an important process that requires not just one conversation with a service user but often multiple conversations with a patient and their whānau. This cannot happen in a hurried and pressurised environment. The health care system has a responsibility to provide good quality time for these important conversations to take place.

These interactions are especially important given the significant rates of poor health literacy in New

Zealand. Poor health literacy has been – and often still is – regarded as a deficiency in the service user. But it is now well recognised that health professionals have a key responsibility in lifting heath literacy levels in the ways they communicate with service users. This is more than simply being extra conscious of using user-friendly language. It requires understanding different dimensions and stages of health literacy and the necessary tasks for improving comprehension. It requires understanding and applying principles of adult learning theory to the delivery of health services. Not least, it requires cultural competency. The evidence points to a need for district health boards (DHBs) to ensure all health professionals have access to the necessary education programmes. For SMOs, it means having the time to take part in such programmes as part of their continuing medical education.

In order to better organise services around the needs of the individual patient, SMOs also require quality time for clinical leadership, including training and mentoring of other clinical staff, fostering stronger clinical teams and collaborating with colleagues and other services to develop evidence-based innovations for more effective, integrated care.

As the Association of Salaried Medical Specialists (ASMS) has found from its own research of the SMO workforce, however, growing clinical workloads are squeezing out the time needed for these activities, even though they are essential parts of SMOs' work. Surveys of heads of department in five DHBs* found many believed their departments lacked sufficient internal SMO cover for training and mentoring, short-term sick leave, annual leave and continuing medical education leave. Many also believed their staff had inadequate time to spend with patients and their families to provide good quality patient centred care.

These finding are reinforced in three major national surveys of SMOs on the safety and quality of their workplaces. The first found many SMOs routinely go to work when they are ill because their patients and colleagues suffer if they take time off sick. In the second survey, 50% of respondents reported symptoms of burnout. In the third, a quarter of SMO respondents indicated they intended to leave either medicine or their DHB in the next five years, with age, poor job satisfaction, negative workplace culture, remuneration and heavy workloads cited as some of the factors influencing their thinking about their future work intentions.

To date, the policy response to increasing clinical workload pressures has been to focus attention on finding and developing new models of care that might provide more services with fewer resources. Theoretically, new, more efficient models of care will free up time for SMOs, allowing them to spend more time on providing a quality patient centred service. But the evidence on new or proposed models to date, such as transferring some SMO tasks to other health professionals, and greater use of new technologies, suggests any impact they may have on current and future demand for specialists would be, at best, marginal, and could in fact simply shift additional work pressures onto other over-stretched clinicians, such as general practitioners or nurses.

Our health policy makers have for some years been focused on budgets, throughputs, 'production', politically selected targets, and seeking 'magic bullets' that will produce more and better health services for less cost. For many senior doctors the expectations generated through some of these policies are divorced from the real world they work in, which may often be behind a perceived reluctance to embrace (usually top-down) change. And while the delivery of these health policies depends largely on how well the 'front line' of the health system functions, policymakers appear to be in denial about the extent to which that front line is struggling, as evidenced by the ASMS research discussed here.

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* Hawke's Bay, MidCentral, Capital & Coast, Nelson-Marlborough, and Counties Manukau DHBs.

Consequently, what has been seriously missing from New Zealand's health policy is a detailed action plan with the goal of seeing the front line in measurably good health. A vital part of this plan would be to create a culture in the health sector workplace which enables that critical part of patient centred care – the interaction between doctor and patient – to be as effective as it needs to be. The quality of that interaction is a litmus test for the quality of the system. This recognises what the literature on patient centred care makes very clear: that to succeed, the patient centred care approach must first address the needs of those who are caring for them.

There is a raft of evidence on what makes a healthy, productive workplace. For the SMO workforce, two overriding and interrelated issues are paramount.

First is the long-standing need to urgently address SMO workforce shortages. A genuine patient centred care service cannot happen while doctors are burnt out and lack time to do what is routinely necessary for safe and good quality practice.

Second is a real commitment to medical engagement. This means far more than producing an 'engagement strategy', or selecting a handful of 'engagement' examples for the annual report. Engagement is built on authenticity. Organisations that engage both staff and service users have strong values of trust, fairness and respect which are consistently articulated and acted upon. This means breathing life into distributed clinical leadership.

These two measures are not optional extras if patient centred care is to become a reality. They require a genuine investment approach where additional investment is made in the SMO workforce in order to produce greater returns in terms of higher quality and more cost-effective services. As discussed in these pages, the evidence for this is compelling.

Dr Hein Stander
ASMS National President

Much health inequity is attributable to systemic factors in medical practice. These reflect not only the knowledge, skills and awareness of doctors, but also structural factors in the medical workplace.

Executive summary

What is 'patient centred care'?

Patient centred care is being promoted as an important 'new' approach to delivering health services as part of the response to meeting the challenges of increasing health service needs and changing service user* expectations. Ultimately, patient centred care derives from the healing relationships between clinicians and service users. Key aspects of patient centred care are:

- a 'whole person' approach to care that considers an individual's needs as a whole rather than treating medical problems in isolation (recognising increasing rates of co-morbidities)
- flexible care that tailors support according to an individual's personal priorities and needs
- a collaborative relationship between patients and the professionals involved in caring for them.

Why is it important?

There is growing evidence that when the service user–doctor interaction is good, the quality and safety of health care rise, costs fall, and levels of patient and staff satisfaction increase. Potential benefits for patients include better health outcomes through improved adherence to prescribed treatment, improved recovery, shorter hospital stays, improved psychological adjustments and mental health, and fewer medical errors. The quality of patient–doctor communication is also critical in supporting people with long-term conditions to develop the knowledge, skills and confidence they need to better manage their own health and care.

If a patient centred care approach is to succeed, however, it must address staff needs. The ability of health staff to care effectively for patients is compromised if they are not cared for themselves.

The time barrier

Commonly identified barriers to delivering patient centred care include time constraints, workload, inadequate communication skills, poor patient health literacy, lack of leadership and, for some clinicians, an unwillingness to change. From the senior medical officer (SMO) workforce perspective, a common factor, directly or indirectly, is time.

Time pressures hinder strong multidisciplinary teamwork and effective integration with other services, both of which are critical for patient centred care.

When senior doctors are empowered to design and manage effective systems in their workplace through a system of distributed clinical leadership, patients and staff benefit. However, ASMS surveys have found many senior doctors are unable to find sufficient time for clinical leadership, and many feel their DHB is not committed to it.

Strategies to engage patients in their health care highlight the importance of enabling senior doctors to undertake continuing professional development in communication skills and training in patient centred values. ASMS surveys indicate significant numbers of senior doctors rarely or never have access to the recommended non-clinical time, which includes time for continuing professional development.

Supporting people to engage as partners in care

Addressing poor health literacy in New Zealand is fundamental to achieving effective service user engagement.

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* 'Service user' is used in this publication as an all-encompassing term covering patients, families and whānau and potential service users (ie, the community). It is an alternative to the more commonly used 'consumer', which is used only in quoted text.

Poor health literacy not only inhibits service users' participation in decision-making about their care, it is also associated with poorer health outcomes. They are less likely to manage their long-term or chronic conditions effectively, are more likely to be hospitalised because of a chronic health condition, are more vulnerable to workplace injury, are less likely to be involved with preventive services, and are more likely to use emergency services.

Addressing poor health literacy requires a system-wide response. A key responsibility for ensuring service users are well informed and understand the relevant information to genuinely participate in decisions about their care lies with health professionals.

The evidence on the quality of health communication generally – including that of senior doctors – indicates big improvement is needed.

Continuing training and education opportunities must be available, where necessary, to ensure all SMOs are equipped with good communication skills, as well as having suitable opportunities – including time and place – to enable genuine two-way communication.

Engaging with Māori as partners in care

Māori health status remains unequal with non-Māori across almost all chronic and infectious diseases as well as injuries, including suicide.

The underlying causes go back most strongly to colonisation, and loss of land, language and identity. Its effects are expressed as systematic social, political, historical, economic and environmental determinants of health, accumulated during a lifetime and transferred across multiple generations.

Much health inequity is attributable to systemic factors in medical practice. These reflect not only the knowledge, skills and awareness of doctors, but also structural factors in the medical workplace. By developing their cultural competency, doctors can bring about improvements in communication, acceptability of treatment, and success of treatment plans for Māori whānau and thereby improve Māori health outcomes. Such improvements will be enhanced by organisation-wide improvements to achieve health care settings that are culturally safe.

Improvements to cultural competency and safety are a continuing process. Cultural awareness training is not enough in itself. Information components are generally well-received and can be developed over a relatively short period of time, but changing skills, awareness and organisational practice requires ongoing effort and engagement.

Telemedicine and patient centred care

The New Zealand Health Strategy's aim for people to be 'health smart' with information to give them greater control over their health relies heavily on digital technologies, including telemedicine (TM).

A key driver of TM has been its potential to improve access to clinical services that would otherwise be unavailable, especially in rural areas. Another driver has been the need to find a solution to addressing increasing health need within constrained budgets. But despite significant ongoing public and private investment in TM, its value is contested, which in turn has led to a slow uptake.

TM services, when they are thoroughly assessed as being appropriate to the circumstances, and are properly planned and resourced, can complement effective health care delivery, but the available evidence shows they are not a panacea, and the evidence for cost-effectiveness is weak.

A commonly identified critical factor for successful implementation of TM is engagement with the end-users (service users and clinicians) in the appropriateness, design, development and use of the technology.

More investment is needed in carrying out credible evaluations of the potential benefits of TM.

Making time for patient centred care

Patient centredness is not a checklist, a dashboard or an action plan. The literature describes it as ‘a cultural transformation’. It is about engaging the hearts and minds of the entire organisation’s workforce, not least senior doctors, whose interactions with patients and their families lie at the heart of patient centred care.

Strong distributed clinical leadership is critical to securing a workplace environment that is conducive to achieving genuine patient centred care, recognising that patient centred care and clinician care are two sides of the same coin. Poor work environments contribute to stress and burnout, staff turnover and medical errors; positive work environments promote high quality care and cost efficiency, and a more stable workforce.

Priorities, with respect to the SMO workforce, are:

- addressing entrenched SMO shortages
- implementing measures to reduce stress and create safe and health workplaces
- genuine commitment to establishing distributed clinical leadership throughout the system
- establishing staffing levels that ensure SMOs have proper access to continuing medical education and time for clinical leadership.

Some government policies have posed barriers to creating the conditions for patient centred care. Policies and priorities need to be better aligned to support them.

Introduction

The well documented challenges facing our health system, including increasing health needs through a growing and aging population, and growing public expectations, has policymakers around the world searching for new ways to deliver services in more innovative and cost-effective ways. There have been major restructurings, targeting, and much talk about introducing 'new models of care' (notwithstanding that new models of care have been evolving since health systems began). One such 'model' is 'patient centred care'.

The concept of patient centred care has been around for some decades, but not until relatively recently has it attracted much attention from policymakers around the world, including in New Zealand. For politicians and district health board (DHB) senior management, the phrase has an attractive, feel-good ring – and because there is no universally accepted definition for patient centred care, its meaning is malleable.

For doctors, talk of patient centred care draws a mixed response. Some argue they have always been patient centred. Patients are, after all, what they go to work for. But when New Zealand's service priorities are to balance budgets and meet targets, and the news is filled with stories of overflowing emergency departments, understaffed hospitals, and long delays in timely treatment for patients, there is growing recognition that providing care which genuinely centres on people's needs and priorities often falls short of what we should expect from a modern health system.

It is for these reasons that the Association of Salaried Medical Specialists (ASMS) produced a series of discussion papers in 2016 to promote the patient centred care approach. It is of course an expansive topic, including governance issues, patients' involvement in policy development, health literacy, medical culture, use of information technology and inter-sectorial collaboration. There are also multiple models and frameworks for describing patient centred care, with many overlapping elements. Further, it is important to recognise the need for a *population* perspective to quality improvement in the health system. This involves a broader 'people centred' care approach that requires consideration of not only appropriate health care and timely access to care, but also the underlying determinants of health, health equity and of families and communities.[1]

Rather than attempt to cover such a wide range of issues, the papers concentrate on the 'sharp end' of health care – examining the policies and conditions that support high quality interaction between patient and clinician – for there is broad consensus that this is where ultimately patient centred care is determined.

Patient and staff experiences are inextricably intertwined, so to approach patient centred care as exclusively about patients is to overlook a critical piece of the puzzle. The insights of staff at the clinical team level provide crucial intelligence for fostering an environment supporting high-quality patient–clinician interaction. This requires strong distributed clinical leadership. Involving senior doctors in the design and implementation of patient centred processes is an important way to ensure the whole clinical team is engaged in these endeavours.

There is now strong consensus internationally that distributed clinical leadership is the required model to meet the challenges facing health care systems around the world. Distributed clinical leadership and patient centred care go hand in hand. Together, the evidence shows they not only lead to better quality and safer care but at the same time they also reduce health care costs.

This *Health Dialogue* brings together updated versions of the first four discussion papers, with additional sections on service user engagement, engagement with Māori, and the use of telemedicine, including the implications of each for senior doctors. The ASMS is grateful for the valuable feedback received from members on the discussion papers and particularly on drafts of the section on engagement with Māori.

Patient centred care: an approach for improving quality and safety

At a glance

Patient centred care is being promoted as an important approach to delivering health services as part of the response to meeting the challenges of increasing health service needs and changing service user expectations. Ultimately, patient centred care derives from the healing relationships between clinicians and service users. Key aspects of patient centred care are:

- a 'whole person' approach to care that considers an individual's needs as a whole rather than treating medical problems in isolation (recognising increasing rates of co-morbidities)
- flexible care that tailors support according to an individual's personal priorities and needs
- a collaborative relationship between patients and the professionals involved in caring for them.

Patient centred care: a description

Organising health care around the needs of the patient may seem an obvious approach to take, but in systems as complex as health care delivery, under constant pressure to do more for less, 'patient centred care' has often been viewed as 'nice to have' but not a fundamental aspect of a health organisation's attention.[2]

So, although the concept of patient centred care has been researched, discussed and promoted internationally for some decades, it has struggled to gain traction as a fundamental driver to the way health care is delivered. That it remains largely aspirational is also due in part to the difficulty in pinning down a definition that enables health service providers to have a clear understanding of what it means in practice.

Patient centred care is often defined by what it is not – namely, disease-centred, technology-centred, physician-centred, or hospital-centred care. Patient centred care, likewise, is not simply capitulating to patients' requests, nor is it simply giving people access to more information and leaving them to sort it out.[3] Further, it does not replace good quality medicine; it both complements clinical excellence and contributes to it through effective partnerships and communication.[4]

But while there is no globally accepted definition of patient centred care, modern concepts are based largely on research conducted in 1993 by the now-multinational Picker Institute, in conjunction with the Harvard School of Medicine. This research identified eight dimensions of patient centred care:[5]

- respect for patients' preferences and values
- emotional support
- physical comfort
- good communication, including access to quality information
- continuity and transition of care
- coordination of care
- the involvement of family and friends
- access to care.

According to the International Alliance of Patients' Organizations, the most common element in definitions of patient centred care is respect for the needs, wants, preferences and values of patients.[6]

It means that the varying needs, capabilities and preferences of individual patients and their carers must be met on an individual basis. Some want more involvement in their care, some are content with a strong professional lead. Some are familiar with new technologies, some are not. It means our health services will need to personalise care according to individual circumstances.

Three core, interrelated elements of patient centred care have been described as:[7]

- A 'whole person' approach to care that considers an individual's needs as a whole rather than treating medical problems in isolation. This approach recognises that an increasing proportion of health care users have multiple long-term conditions – often including both physical and mental health problems. It appreciates that these conditions, and the medical interventions to treat them, may interact in complex ways and provides a coordinated, long-term response to health, care and support needs that transcends professional and organisational boundaries.
- Flexible care that tailors support according to an individual's personal priorities, needs and individually defined outcomes. This means going beyond a narrow focus on treatment of medical problems, to an understanding of people's lives, their environment, their personal values and their goals.
- The need for a collaborative relationship between patients and the professionals involved in caring for them, through which patients are empowered to be equal partners in their own care. For this to happen, patients require good information about lifestyle risks and benefits and, when appropriate, the treatment options open to them.

In New Zealand, the Code of Health and Disability Services Consumers' Rights Regulation 1996 (the Health and Disability Code) and the New Zealand Ministry of Health's document *Improving Quality: A systems approach for the New Zealand health and disability sector*[9] established patient centred care as a priority, at least in principle.[10] In the latter, the patient centred care approach includes adherence to the Health and Disability Code and adherence to other consumer protections such as the Heath Information Privacy Code 1994. By referencing the Health and Disability Code, this document acknowledges patients' *rights* as integral to patient centred care – a common omission in other definitions.

DHBs may be able to tick off most, if not all, of the above aspects of patient centred care. And most senior doctors may well see themselves as 'patient centred', but many of our operational structures, conditions and policies, especially in hospital-based care, work against it, whether it is restrictive visiting hours, poorly integrated services, staff shortages, or policies with a focus on budgets, throughputs, production, and targets which have been described as dehumanising health care.[11, 12]

Policies to promote patient centred care often focus on infrastructural changes. These changes, such as electronic health records, may be necessary to move medical care into the 21st century, but they should not be conflated with achieving patient centred care. Simply implementing an electronic health record in itself is not patient centred unless it strengthens the patient–doctor relationship, promotes communication about things that matter, helps patients know more about their health, and facilitates their involvement in their own care.[13]

The evidence suggests a truly patient centred organisation will perform well on quality measures such as patient safety, timely treatment, equitability, and accessible services. New Zealand's health service performance indicators, however, show there is considerable room for improvement in all these areas.

Successful implementation of patient centred care may involve a broad range of activities including developing strong leadership, patient and health professional education, patients' involvement in

Effective patient centred communication means tailoring communication to the individual.

policy development and feedback on performance, developing the uses of information technology, improving data collection, and inter-sectorial collaboration. There are also multiple models and frameworks for applying patient centred care, with many overlapping elements.

However, for all of the many aspects to patient centred care, there is broad consensus that ultimately it derives from the healing relationships between clinicians and patients and, by extension, patients' family members. A patient centred approach fosters interactions in which clinicians and patients engage in two-way sharing of information, explore patients' values and preferences, help patients and their families make clinical decisions, facilitate access to appropriate care, and enable patients to follow through with often difficult behavioural changes needed to maintain or improve health.[3]

Why is patient centred care so important?

At a glance

There is growing evidence that when the patient–doctor interaction is good, the quality and safety of health care rise, costs fall, and levels of patient and staff satisfaction increase. Potential benefits for patients include better health outcomes through improved adherence to prescribed treatment, improved recovery, shorter hospital stays, improved psychological adjustments and mental health, and fewer medical errors. The quality of patient–doctor communication is also critical in supporting people with long-term conditions to develop the knowledge, skills and confidence they need to better manage their own health and care. If a patient centred care approach is to succeed, however, it must address staff needs. The ability of health staff to care effectively for patients is compromised if they are not cared for themselves.

If patient centred care is ultimately determined by the quality of the interaction between patient and doctor, the first question to address is how good that interaction is.

According to recent patient experience surveys overseen by the Health Quality & Safety Commission (HQSC), 9 out of 10 New Zealand public hospital patients feel staff always treated them with dignity and respect while they were in hospital. Less impressive, however, are the survey responses concerning the information patients received from health professionals about their treatment and condition, and the extent of involvement in decisions about their care and treatment.[14]

For example, just 73% of respondents could give a definite 'yes' to the question: 'Was your condition explained to you in a way that you could understand?' Only two-thirds of patients felt they were involved as much as they wanted to be in care and treatment decisions, and only half said they were given a full explanation about medication side-effects to watch for when they went home. Such survey results are not unusual in the health systems of other comparable countries.[15]

Internationally, end-of-life care features in many discussions about patient centred care. New Zealand's demographic trends point to a continuing rise in the number of people dying each year, with an increasing proportion dying over the age of 85. This is likely to have a significant impact on health services as many service users will be requiring treatment and care in a frail condition. Many will have multiple chronic illnesses which, especially when frail, will require complex treatment options and a high degree of individualised care.

Patients who are in the last year of their lives may receive input from a great number of medical and non-medical health professionals in a range of care settings and are likely to present repeatedly. When patients become frail, the effectiveness of some medical interventions tail off. Many patients, such as those with advanced dementia, may no longer be able to express their wishes. Ensuring that these patients (and, where appropriate, their families) are well informed and involved in deciding treatment decisions can be challenging.[16]

These are not issues unique to New Zealand, of course. Nor are they new, but the health service implications of growing and aging populations, along with attempts to improve cost-effectiveness of services, have prompted an international campaign, Choosing Wisely, to promote a culture where low value and inappropriate clinical interventions in all age groups are avoided, and service users and clinicians have well-informed conversations around their treatment options, leading to better decisions and outcomes. The campaign is being facilitated in New Zealand by the Council of Medical Colleges, with wide sector support, including the ASMS.[17]

According to an international 'Quality of Death Index' devised by The Economist Intelligence Unit (EIU) in the United Kingdom (UK), New Zealand does well on the overall quality of its palliative care, ranking third out of 80 countries (behind the UK and Australia).[18] However, the EIU adds the caveat that even in those countries that score well there is evidence of service failings. It cites a UK ombudsman's investigation into complaints about end-of-life care, which found regular occurrences of poor symptom control, poor communication and planning, not responding to the needs of the dying, inadequate out-of-hours services, and delays in diagnosis and referrals for treatment.[19]

Significant shortcomings have also been reported in New Zealand. While the need for palliative care will increase considerably in the coming decade, Ministry of Health projections indicate the number of palliative medicine specialists will fall.[20] On current workforce trends New Zealand is projected to have less than 70% of the palliative specialists needed in the next 5 to 10 years, at a time when they are becoming increasingly in demand internationally.[21, 22]

A Royal Australasian College of Physicians (RACP) survey of fellows' and trainees' attitudes, knowledge and practice of end-of-life care and advance care planning found indications that many patients nearing the end of life are provided with treatment that is inappropriate or against their wishes. About a third of respondents who cared daily for patients who could die in the following 12 months observed treatment being given that was inconsistent with the patient's wishes at least once a week. Of all respondents, 37% indicated they had observed treatment with little chance of significant benefit being provided to patients at least once per week. This was observed by 44% of trainees. Only 17% of respondents to the RACP's survey agreed that 'most of the time doctors know the patient's preference regarding end-of-life care'.[16]

The evidence for patient centred care

Shortcomings in patient–doctor interaction have been reported in numerous studies internationally, yet there is growing evidence of the many benefits when that interaction is good: the quality and safety of health care rise, costs decrease, and doctor and patient satisfaction increase. Research findings demonstrate that effective communication heals, and that sub-standard communication may have negative health effects.[23, 24, 25]

For example:

- Patients reporting good communication with their doctor are more likely to be satisfied with their care, and especially to share pertinent information for accurate diagnosis of their problems, follow advice, and adhere to the prescribed treatment.[26, 27, 28, 29, 30, 31]
- Patients' agreement with the doctor about the nature of the treatment and need for follow-up is strongly associated with their recovery.[32, 33]
- Good patient–doctor interaction can improve patients' health outcomes.[28, 34, 35]
- Good patient–doctor interaction can improve patient safety and reduce medical error rates.[36, 37, 38]
- Studies have shown good patient–doctor communication improves the control patients feel over their care and treatment, which in turn can have a positive impact on their ability to manage pain, recovery from illness, and daily functioning.[3, 39, 40]
- Good patient–doctor interaction can improve patients' psychological adjustments and mental health.[27, 28, 33, 41, 42]
- Some studies have observed good patient–doctor communication can shorten the length of hospital stay and therefore reduce the cost

of individual medical visits and result in fewer referrals.[26]

The quality of patient–doctor communication is also critical in supporting people with long-term conditions to develop the knowledge, skills and confidence they need to better manage their own health and care. As the population ages, increasing numbers of people are living with long-term conditions which account for a significant portion of total health services. It is estimated that two out of three New Zealand adults have at least one long-term condition, and it's the leading cause of preventable death.[43, 44]

Patients perceive that self-management of their condition can be facilitated when clinicians and patients view health care as a shared responsibility, underpinned by clinicians as experts in the disease and patients as experts in living with it.[45]

Self-management can save money as well as being clinically effective. Currently, there are two main models of self-management support: group-based patient education programmes and patient–clinician collaboration within routine consultations.[43, 46] This second model should improve access to self-management support, be deliverable where capacity is not available within teams for lengthy group programmes, and benefit patients who would not attend a group. There is evidence that patients want assistance with managing their health conditions. For example, a UK survey with more than 1200 rheumatology patients with inflammatory arthritis found that 82% wanted help with managing the impact of pain and fatigue and 57% to manage emotions, and 66% reported that they would access a self-management support clinic.[45, 47]

Supporting patients with long-term conditions to manage their health and care can improve clinical outcomes. When people are more involved, they are less likely to use emergency hospital services. They are also more likely to stick to their treatment plans and take their medicine correctly.[43, 48]

Patients who have the opportunity and support to decide their care and treatment in partnership with health professionals are more satisfied with their care,[49] are more likely to choose treatments based on their values and preferences rather than those of their clinician,[50] and tend to choose less invasive and costly treatments.[43]

Individuals who have more knowledge, skills and confidence to manage their health and health care are more likely to behave in ways that help them be healthy, and to have better health outcomes.[51]

If a patient centred care approach is to succeed, however, it must address staff needs. The ability of health staff to care effectively for patients is compromised if they do not feel cared for themselves.

Once the patient centred care approach is firmly established, a positive cycle emerges where increasing patient satisfaction also increases employee satisfaction, and this, in turn, improves employee retention rates and the ability to continue practising patient centred care. As patient engagement increases, staff performance and morale see a corresponding increase.[52]

There is growing evidence that when the patient–doctor interaction is good, the quality and safety of health care rise, costs fall, and levels of patient and staff satisfaction increase.

The time barrier

At a glance

Commonly identified barriers to delivering patient centred care include time constraints, workload, inadequate communication skills, poor patient health literacy, lack of leadership and, for some clinicians, an unwillingness to change. From the SMO workforce perspective, a common factor, directly or indirectly, is time – the critical resource necessary to enable patient centred care to fulfil its potential.

Time pressures hinder strong multidisciplinary teamwork and effective integration with other services, both of which are critical for patient centred care.

When senior doctors are empowered to design and manage effective systems in their workplace through a system of distributed clinical leadership, patients and staff benefit. However, ASMS surveys have found many senior doctors are unable to find sufficient time for clinical leadership, and many feel their DHB is not committed to it.

Strategies to engage patients in their health care highlight the importance of enabling senior doctors to undertake continuing professional development in communication skills and training in patient centred values. ASMS surveys indicate that significant numbers of senior doctors rarely or never have access to the recommended non-clinical time, which includes time for continuing professional development.

Time pressure on doctors

An RACP survey of fellows' and trainees' attitudes, knowledge and practice concerning end-of-life care and discussions with patients about future health care options through advance care planning processes found many patients nearing the end of life are provided with treatment that is inappropriate or against their wishes.[16]

Of all respondents to the RACP survey, 34% had commenced an Advance Care Plan conversation with a patient in the past six months and 32% had not done so. The survey identified the following potential barriers to undertaking advance care planning:

- time constraints (62%)
- insufficient relationship with patients (46%)
- health literacy of the patient or family (41%)
- lack of skills of the doctor (30%)
- discomfort in having end of life or advance care planning conversations (26%)
- unavailability of appropriate place for discussions (20%)
- patients aren't interested (18%)
- language barrier (16%).

Most of these identified barriers are directly or indirectly related to the doctor's time – whether it is time to have the (sometimes many) conversations with the patient and family, especially if the patient has difficulty understanding the information, or whether it is time for the doctor to undertake skills training or obtain other support as needed.

The doctor's time factor arises frequently in the literature discussing barriers to patient centred care.[23, 26, 38, 53, 54, 55, 56]

A systematic review of health professionals' perceptions of the barriers and facilitators to implementing shared decision-making in clinical practice found the most often reported barrier to shared decision-making is time constraints (18 of 28 studies).[57] The review included the views of more than 2784 health professionals from 15 countries (most of them doctors).

An English survey of National Health Service (NHS) clinicians and managers seeking their views on the factors affecting the quality of patient care and the role of leadership in delivering improvements found 'time and/or resources' were considered the biggest obstacle to improving patient care.[52]

An Australian study involving interviews with chronically ill patients and their (non-health professional) carers about their experiences with the health system found:

> *"One of the most common challenges experienced by participants related to insufficient GP and specialist consultation time. Consultations concentrated on the immediate problem, leaving little time to discuss warning signs of emerging problems associated with the chronic illness…"*

Interviews with health care professionals in the same study reinforced patients' observations that poor communication was a major barrier to good health care. They linked this to patients' low levels of health literacy, but also saw limited time and human resources as 'significant barriers'. They observed that specialists *"are often busy and lack sufficient time to provide thorough information"*. They also suggested that patients and carers sometimes hesitated to ask questions of doctors due to doctors' time constraints.[58]

Similar time pressures have been identified in New Zealand, which has fewer specialists per head of population than most other countries cited in the literature on patient centred care. Surveys of heads of department in five DHBs to ascertain the adequacy of current SMO staffing levels to meet local health needs indicate time pressures on SMOs are compromising the quality of care. Many respondents – the majority in two DHBs – believed their staff had insufficient time to spend with patients and their families to provide good quality patient centred care.[59]

Time pressure on multidisciplinary teams

Time pressures not only affect patient–doctor communication but also communication between clinicians. While much of the literature on patient centred care focuses on patient–clinician interaction – and the actions of each individual clinician are critically important – achieving the patient centred care objectives usually requires well-coordinated teams of health care professionals working together with these goals in mind.[60] Effective team performance can in turn have a positive impact on quality and patient safety. The safety literature emphasises the value of highly collaborative teams and links them to error reduction and effective performance in multiple settings.[4, 61]

Multidisciplinary meetings form the lynchpin of effective teamwork by providing a forum for interdisciplinary communication, decision-making and co-ordination of care. However, time pressures are often seen as a major barrier to organising regular team meetings.[62, 63, 64]

An English study examining staff perceptions of team-working in the field of stroke care found: *"Staff often raised concerns regarding team functioning to issues of time, and expressed concern at the need to balance patient contact time against team-working time."* Multidisciplinary meetings for example were identified as an important decision-making forum, but staff expressed concern at the time taken up by them during a working week, and how they often were required to make choices between these and patient contact time, as illustrated in the following staff comments:

> *"To be honest I just see my bit and I don't look at anybody else's bit... which maybe I should...but I just don't have the time."*
>
> *"We don't generally go in for goal setting... cos we haven't got time."*

> *"It can be frustrating because again that takes time out to be able to communicate to pass that knowledge on or be open to other people's opinions, um... takes time out of what it is you are wanting to do, so if you've got your day planned and you've got six or seven sessions in and you want to see those patients... if you need to take the time to pass that knowledge on or gain more knowledge that obviously has an impingement on time."*[65]

Staff concerns regarding the time taken up by team-working echo the findings of an earlier three-year study on the effectiveness of discharge planning and multidisciplinary teamwork, which found *"a lack of time due to heavy work pressure… [as] the biggest barrier affecting inter-professional working and coordination of assessments".*[66]

When health care team members do not communicate effectively, patient care often suffers. Research conducted over 10 years to 2005 demonstrated that ineffective team communication was the root cause for nearly 66% of all medical errors during that period.

Further, medical error vulnerability is increased when health care team members are under stress or are in high-task situations.[61]

Staffing and workload demands were identified by doctors and nurses in Britain's NHS as a key underlying cause for reported cases of deterioration of hospital patients which was not recognised or not acted upon and resulted in patient deaths.[67]

A King's Fund study found:

> *"Clinical teams perform best when their leaders value and support staff, enable them to work as a team, ensure that the main focus is on patient care, and create time to care."*[52]

Time pressure on delivering integrated care

Beyond the multidisciplinary team, integration with other teams and other services is also fundamental to providing patient centred care. However, again, increased workloads and time are often identified by clinicians as factors affecting the delivery of integrated care.[68]

Studies show that providing integrated care demands extra time from clinicians to communicate patient details with other service providers (eg, social worker and GP),[69] increased administrative duties,[70] and a general increase in the volume of work.[71] Stress and fatigue have been identified as having an impact on staff,[69] and concerns about overloading staff are also evident.[70, 72] One study also indicated that integrated care models may necessitate increased staff responsibilities within the same role and salary level, which, when coupled with a culture of longer working hours and a feeling of 'always being on duty', may not be received positively.[73]

Time for leadership

Effective clinical leadership is another key factor in achieving patient centred care.[24, 52, 74]

However, in 2010 a national survey of ASMS members on the application of clinical leadership in DHBs found a mere 20% of respondents believed they have enough time to engage in clinical leadership activities or development programmes.[75]

Following the survey of ASMS members in 2010, two further surveys of members, conducted in 2013 and 2015, examined the performance of chief executives, senior managers, middle managers and human resource managers. Members were asked to assess their DHB's level of genuine commitment to distributive clinical leadership in its decision-making processes. In 2013, just 30% of respondents felt their DHB was genuinely committed to distributive clinical leadership, while 47% felt their DHB was not genuinely committed, and 23% didn't know.[76] By 2015 the findings were virtually unchanged.[77]

The likelihood of clinical leadership (and by implication patient centred care) being afforded greater priority for senior DHB managers was set back when the Minister of Health's annual 'Letter of Expectations' to DHBs for 2016/17 omitted any reference to the importance of clinical leadership for the first time since the early 2000s. Reference to clinical leadership was reinstated in the 2017/18 letter (following a formal letter from ASMS expressing serious concern about the omission) but with much less emphasis than in previous letters.

Strong commitment to patient centred care from senior health service management – and of course Government – is considered critical for its success. But while there is no available information to gauge this level of commitment, the evidence of senior management commitment to supporting distributive clinical leadership raises doubt about its commitment to genuine patient centred care.

Time for skills training and continuing education

Strategies to engage patients in health care highlight the importance of enabling clinical staff to undertake continuing professional development in communication skills and training in patient centred values.[24, 61]

The RACP's report on its survey of fellows' and trainees' attitudes, knowledge and practice concerning end-of-life care and advance care planning notes that although a majority of respondents had taken part in communication skills training, and many had completed training in advance care planning, they wanted to continue to improve their skills in these areas.

There is no readily available information to indicate the availability of such training programmes across the country, or how much they are supported by DHB management. However, findings of the surveys of heads of department in five DHBs to ascertain the adequacy of current SMO staffing levels (discussed above), show many heads of department (ranging from 14% to 57% of respondents) believed their SMO staff 'never' or 'rarely' accessed the recommended level of non-clinical time.

Workforce capacity

To succeed, a patient centred care approach must address staff needs, including staff capacity, because the staff's ability to care effectively for patients is compromised if they do not feel cared for themselves.[24, 25] A study involving interviews and surveys with patients, managers and nursing and medical staff concluded: *"Individual employee wellbeing is an antecedent, rather than a consequence, of patient care performance."*[78]

However, in New Zealand and overseas, health service staff morale has been hit by staff shortages and policies with a focus on budgets, throughputs, production, and targets which have been described as 'dehumanising',[79, 11] and 'industrialisation' of health care where the role of medicine is changing from *"a craft concerned with the uniqueness of each encounter with an ill person, to a mass manufacturing industry preoccupied with the throughput of the sick"*.[12]

The time pressures on doctors discussed in this paper are in part a reflection of entrenched specialist shortages in New Zealand, exacerbated by increasing health need, an aging workforce, and a heavy dependence on international medical graduates (IMGs) which puts services in a vulnerable position because of the increasing international competition to attract specialists.[80, 81, 82]

Shortages of medical specialists have been acknowledged by Health Workforce New Zealand (HWNZ):

> *"The most important issue currently is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors."*[83]

Partly as a consequence, burnout of doctors is commonplace.

> *"The increasingly high levels of job burnout observed among physicians globally is set to continue as fewer resources and tighter budgets ratchet up the personal and professional pressure."*[84]

The evidence suggests that burnout has major repercussions for patients and employers, including poorer perceived and real patient care along with higher staff turnover.[85]

The ability of health staff to care effectively for patients is compromised if they do not feel cared for themselves.

A survey of New Zealand hospital doctors published in 2004 found nearly 30% of respondents suffered psychological distress, with 10% classified as severe. The most frequently reported stressful situations were associated with work demands, commonly found in other studies.[86, 87]

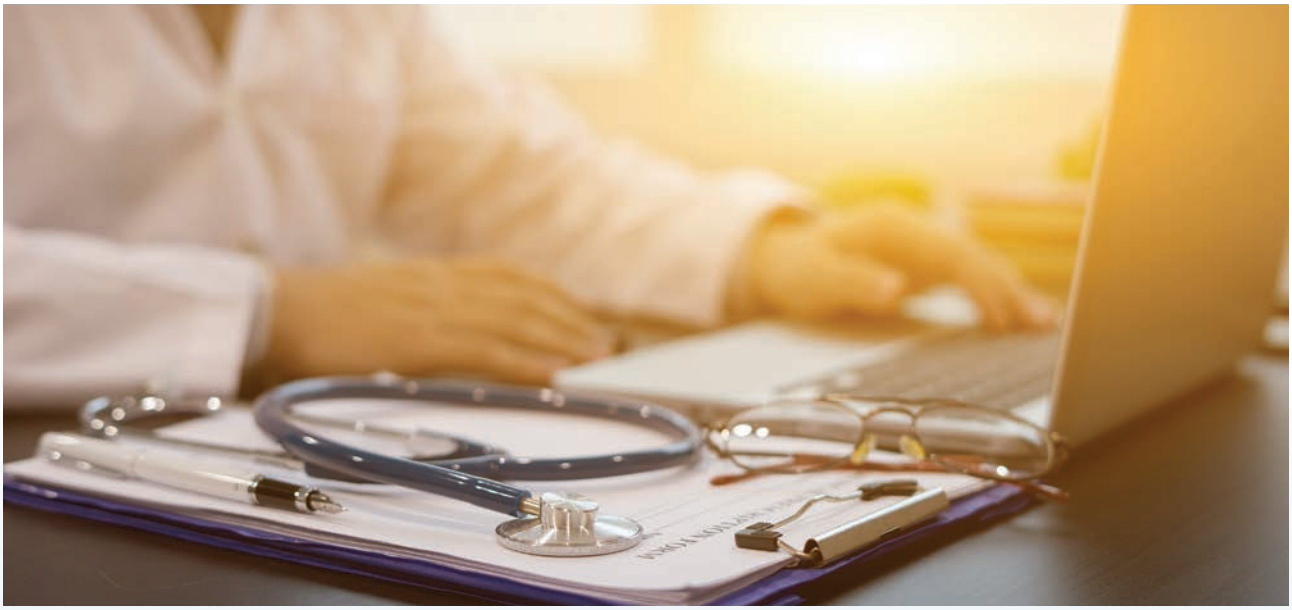
A study involving 267 consultants from a wide range of specialties at Canterbury DHB in 2006/07 found one in five had symptoms of high burnout, with long work hours and low job satisfaction being key contributory factors. A quarter of the respondents reported working longer than 60 hours per week.[88]

An ASMS survey of DHB-employed SMOs to ascertain levels of burnout found half (50.1%) of the 1487 respondents reported symptoms of burnout, and 42.1% of respondents attributed burnout to the workplace, as illustrated in the following comments from respondents:[89]

> *"…the acuity of the patients in our service has increased without enough staff to treat these patients. Non-clinical time has disappeared in consequence. Burnout is happening on the other members of the team and the SMOs mop up. I'm not ready to retire but am seriously considering moving on."*

> *"…One also needs time to think about the more patients with more challenging conditions and how best to manage them, which seems to be given no value whatsoever. All the system seems to be interested in is how many patients can be booked per clinic and these other tasks appear to be invisible and constantly more is asked of us… It's a quietly stress invoking situation constantly feeling like you're racing against the clock to perform all these various duties in a clinic session."*

A further indication of a medical workforce under stress is demonstrated in a major ASMS study involving 1806 senior doctors which found many DHB-employed SMOs routinely go to work when they are ill.[90] The main reasons for doing so include not wanting to let their patients down and not wanting to over-burden colleagues.



Supporting people to engage as partners in care

At a glance

Addressing poor health literacy in New Zealand is fundamental to achieving effective service user engagement.

Poor health literacy not only inhibits service users' participation in decision-making about their care, it is also associated with poorer health outcomes. They are less likely to manage their long-term or chronic conditions effectively, are more likely to be hospitalised because of a chronic health condition, are more vulnerable to work¬place injury, are less likely to be involved with preventive services, and are more likely to use emergency services.

Addressing poor health literacy requires a system-wide response. A key responsibility for ensuring service users are well informed and understand the relevant information to genuinely participate in decisions about their care lies with the health professionals.

The evidence on the quality of health communication generally – including that of senior doctors – indicates big improvement is needed.

Continuing training and education opportunities must be available, where necessary, to ensure all SMOs are equipped with good communication skills, as well as having suitable opportunities – including time and place – to enable genuine two-way communication.

Service user engagement has been health policy in New Zealand's for many years in one form or another, but while there have been a great many public consultations and surveys, and policies to develop strong partnerships with people and communities, matching reality with the policy intent remains challenging. Addressing poor health literacy in New Zealand is fundamental to making progress.

In New Zealand, health literacy has been defined by the Ministry of Health as *"the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions".*[91] In this definition the focus is most obviously on service user's capability. However, as the Ministry acknowledges, internationally support is growing for a stronger focus on how health systems, health care providers and practitioners can support service users to access and understand health services.[92, 93, 94]

In 2006, a Ministry of Health survey showed that more than half of adult New Zealanders had health literacy skills *"insufficient to cope with the health literacy demands they typically face".* The New Zealand results mirror those of Australia, the United States, Canada, the UK and Ireland.[91, 95, 96] A recent New Zealand report updating the earlier survey findings on literacy and numeracy skills generally indicates little change in this country since 2006.[97]

Poor health literacy not only inhibits service users' participation in decision-making about their care, it is also associated poorer health outcomes, including higher mortality in older adults.[98] People who find it hard to understand or interpret health information are less likely to manage their long-term or chronic conditions effectively, are more likely to be hospitalised because of a chronic health condition, are more vulnerable to work¬place injury, are less likely to be involved with preventive services such as screening, and are more likely to use emergency services.[99, 100, 101, 102, 103, 104] It has been estimated that people with low individual health literacy are between one-and-a-half and three times more likely to experience an adverse outcome.[105]

A systematic review that examined the costs associated with low individual health literacy found that, at a system level, additional costs were equivalent to approximately 3% to 5% of total health care spending.[106]

The importance of addressing poor health literacy is promoted in several recent publications, including an HQSC guide for health professionals, a Ministry of Health guide for health care organisations, and a New Zealand Medical Association (NZMA) *Policy Briefing*, which includes recommendations.[92, 107, 108] Supporting good health literacy is also recognised in the recently revised New Zealand Health Strategy.[109] The Strategy's emphasis is to *"Inform people … so they can be 'health smart'"*, with a key aim to *"Improve coordination and oversight and expand delivery of information to support* ***self-management of health*** *through a range of* ***digital technologies****"* [Strategy's emphases]. The use of digital technologies includes social media and mobile apps 'to support healthy living', interactive computer games 'to support good health and wellness for priority groups', 'strengthened' telehealth services to provide more support for people to manage their own health, and increased use of health information accessible via online patient portals. The ultimate aim is for people to be *"increasingly able to interact with the health system online".*

At the same time, the Strategy's goal to create a 'smarter system', with the aim of taking greater advantage of emerging technologies, will mean the demands for improved health literacy will intensify.[101]

The approaches taken in the Strategy, however, do not acknowledge that addressing poor health literacy requires a concerted effort from across a range of sectors, including the education sector, social welfare, the Accident Compensation Corporation and other government agencies, as well as the entire health care system, including a combined approach where service users and health professionals both take responsibility for improving communication and understanding.[91, 96, 110] Nor does the Strategy acknowledge the risks of placing a heavy reliance on communication via the internet.[111, 112]

Information challenges faced by service users

A chasm often separates what doctors intend to convey in written or spoken communications with service users, and what service users actually understand.[113] This is often attributed to a deficiency in the person on the receiving end of the information.[96]

However, health service users face numerous challenges as they seek health information, including navigating a complex health system, having an understanding of disease theory, being able to interpret and describe health symptoms clearly, understanding the nuances and implications of particular conditions specific to them, evaluating advice amid the proliferation of service-user information available from diverse sources, and the ability to use information to respond, adapt and control life events.

Individuals are asked to assume new roles in seeking information, advocating for their rights and privacy, understanding responsibilities, measuring and monitoring their own health, and making decisions about options for care. As well as being health literate, health service users also need some understanding of other 'literacies' identified in the literature, including scientific literacy, information literacy, media literacy (able to distinguish reliable information from promotions) and, increasingly, computer literacy. In addition, health is only one of many competing aspects of a person's life, even for those most motivated to improve their knowledge.[101, 114, 115]

Given this multitude of challenges, even individuals with good communication and comprehension skills can find it difficult to understand and apply the specific health care information they need, especially when they are more vulnerable and stressed by illness or injury. A large part of the responsibility for lifting health literacy levels therefore must rest with the health service itself, at all levels. As the Ministry of Health puts it:

> *"Health literacy should not depend on the skills of the individual patient and whānau alone. It is an organisational value that should be considered core business, incorporated into all levels of service planning delivery and even the way health centres and hospitals are laid out."*[93]

A key responsibility to ensuring service users are well informed and understand the relevant information to genuinely participate in decisions about their care lies with health professionals, consistent with the broader patient centred care approach.

Since service users' health literacy may vary considerably, there has been a push to introduce health literature screening into routine practice.[116,117] However, screening for health literacy requires health professionals' additional time and resources and risks stigmatising people who score poorly. Many service users with limited health literacy actively hide it. Although these tests offer potential benefits, they can also lead to shame and embarrassment, which can hinder good communication and cooperation and may even alienate patients who already face a significant barrier to accessing health care.[102, 118]

Furthermore, as discussed above, none of the skills and abilities required for good health literacy can be assumed in *any* service user. Often patients who are well educated and hold professional jobs, including in the health sector, may have trouble understanding and applying health care information, especially when it is explained in technical, unfamiliar terms. Patients may be verbally articulate and appear knowledgeable, yet fail to grasp disease concepts or understand how to carry out medication regimens properly, particularly when they are struggling with ill health.[119, 120]

Expert advice now recommends that rather than attempting to identify those 'in need of help', health professionals should assume that all service users have some degree of difficulty, and every patient needs health information that is understandable, meaningful to them, and easy to use.[96, 121]

This 'universal precautions' approach requires clinically led systems to be in place to promote better understanding for service users, aimed at clear communication practices, with tactics including plain language, 'teach back' (asking the recipient to explain the information), slowing down, and supplementing words with pictures. In addition, health professionals are encouraged to improve the written materials they give to patients and to encourage patients to ask questions. If these precautions are applied universally, then health literacy screening becomes superfluous.[119, 120]

However, the evidence on the quality of health communication generally indicates big improvement is needed.

In 2011, a New Zealand Guidelines Group (NZGG) report to the HQSC on health literacy and medication safety found:[95]

> *"Much of the health sector appears largely unaware of the relevance of adult learning theory to health literacy (in either medications safety or more broadly). For all patient-mediated self-management (such as taking medications), an ability of health professionals routinely to create effective learning opportunities for patients in the course of meeting health needs appears underdeveloped. This finding is not a criticism of New Zealand health practitioners; rather it is an indication that the problem is systemic throughout the health sector."*

Similar health service communication shortcomings have been found overseas. Over 300 studies have shown that health information cannot be understood by most of the people for whom it was intended, suggesting that the assumptions regarding the recipient's level of health literacy made by the creators of this information are often incorrect.[101]

This is highlighted in a survey by the American Academy of Orthopaedic Surgeons, which found 75% of surgeons believed they communicated satisfactorily with their patients but only 21% of the patients reported satisfactory communication with their doctors.[29]

Even relatively simple, common terms, such as 'fracture' and 'break', can be confusing to patients when used in medical communication, despite clarification explained in leaflets and posters and access to definitions via the internet.[122] A 1994 study of fracture clinic patients surveyed in the UK showed 81% of respondents believed there was a difference between a fracture and a break and, of these patients, 71% thought a fracture was better than a break.[123] Over a decade later, an audit of patients' perceptions of the terms 'fracture' and 'break' was undertaken to determine whether this misconception was still widely held.[124] Similar results were found to those of the previous study. A follow-up audit was then undertaken introducing a patient information leaflet on broken bones and fractures. However, only 21% of the patients had read the leaflet provided and, of these, few appeared to retain the information, with 69% still believing that there is a difference between a fracture and a break. Further, internet access did not appear to correlate with better awareness regarding this misconception – 80% of those with internet access and 82% of those without were either unsure or thought there was a difference between a 'fracture' and a 'break'.

A 2013 survey of health information producers and providers in the UK (mostly from the NHS) found fewer than half provide services or resources that address the needs of people with low health literacy, and only 10% have a specific policy or strategy. The main barriers faced when producing information for people with low health literacy include limited funds and resources, limited understanding of needs and limited understanding of how to develop appropriate resources or services. The survey reported: *"There is a clear appetite for practical guidance and case studies."*[125]

The appetite among doctors for guidance and support in addressing poor health literacy in New Zealand and Australia is also reflected in the results of the RACP survey of fellows and trainees concerning end-of-life care and discussions with patients about future health care options through advance care planning (discussed earlier in 'Why is patient centred care so important?').[16] The barriers to undertaking advance care planning included health literacy of the patient or family (41% of respondents), lack of skills of the doctor (30%), insufficient relationship with the patient (46%), language barriers (16%) and discomfort in having end-of-life care conversations (26%).

These barriers to effective communication, and the need to provide more ongoing training for doctors, particularly in relation to end-of-life care conversations, is reinforced in other studies.[126]

A system-wide response to poor health literacy

Recognising that addressing poor health literacy requires a system-wide response, in 2015 the Ministry of Health produced a guide to help health care organisations conduct a 'health literacy review' of their operations to identify strengths and weaknesses and develop actions to make the organisation more user friendly. According to the Ministry:[92]

> *"A health-literate organisation:*
>
> - *makes health literacy everyone's business – leaders, managers, and clinical and non-clinical staff*
> - *designs systems, processes and services that allow service users to access services easily*
> - *supports operational staff to use health literacy approaches and strategies*

- *eliminates confusing communication that could prevent service users from accessing treatment easily*
- *actively builds health literacy of service users to help them to manage their health*
- *makes sure operational staff understand that, no matter how high a service user's level of health literacy is, stress and anxiety affect their ability to understand and remember new information."*

The Ministry produced six dimensions of a health-literate organisation, based on the American Institute of Medicine's 10 attributes of a health-literate organisation (Table 1).[127]

A health literacy review includes identifying how an organisation enables its health workforce and leaders to make improvements, and how it supports service users to engage with services.

For the former, most if not all DHBs have established a 'clinical council' or something similar, which aims to provide clinical oversight of organisational decision-making and clinical services delivery. To be effective, however, distributed clinical leadership is needed, where leadership is not just the province of those in positional roles but also where there is a shared responsibility for all clinicians for the success of the service or hospital.[128] Despite this being a central plank of government health policy, implementation has fallen well short of the stated intent.[129] Further, there is limited training for leadership in clinical practice, limited coordination of programmes offered by individual DHBs and no national programme.[130]

Opportunities for clinicians to improve their skills to address poor health literacy are also lacking. As discussed above, the NZGG found a general lack of awareness within the health sector of the role clinical staff have to play in improving health literacy. The NZGG noted that *"understanding in the sector of how to improve health literacy appears limited…"* and *"most health practitioners appear largely unaware of adult learning theory or practice as a body of knowledge".*[95]

TABLE 1: SIX DIMENSIONS OF A HEALTH-LITERATE ORGANISATION

Leadership and management. How is health literacy an organisational value, part of the culture and core business of an organisation or service? How is it reflected in strategic and operational plans?
Consumer involvement. How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?
Workforce. How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?
Meeting the needs of the population. How does service delivery make sure that consumers with low health literacy are able to participate effectively in their care and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?
Access and navigation. How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?
Communication. How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?

Source: Ministry of Health 2015

The NZGG recommended that *"although it is important to address health literacy at 'systematic' and 'organisational' levels, the most immediate task for the health sector is to upskill the health workforce in the application of learning theory to health service delivery".*

The challenges of developing the health literacy skills of service users go beyond the principles of plain language and good design. Effective patient centred communication means tailoring communication to the individual, taking into account factors such as the service user's attitude, their reading skills, the extent to which they can absorb information at any one time, and cultural sensitivity.[93]

Along with the creation of 'clinical councils', some DHBs have established, or are in the process of establishing, 'consumer councils' with the general aim of enabling service user views and feedback to be considered in the planning, development, delivery, evaluation, quality improvement and clinical governance of services. To assist DHBs, the HQSC has produced a guide to engagement, noting that *"While some services are actively seeking to improve consumer engagement, others are struggling."*

Poor understanding within the health sector of its roles and responsibilities in addressing poor health literature is illustrated in the DHB Board minutes of a meeting of one such 'consumer council', following a health literacy review of the organisation, noting:

> *"The Health Literacy Review saw some rigorous discussion by consumer members who had been constantly told they needed to get more literate! The question is how literate is the health sector!"*[131]

It is about engaging the hearts and minds of the entire organisation's workforce, not least senior doctors, whose interactions with patients and their families lie at the heart of patient centred care.

As some commentators have observed:[96]

> *"Health is only one of many competing fields that impact on the lives of people, even for those most motivated to improve their knowledge. It is likely to be more effective to teach providers to communicate well than to try to lift the capacity of patients to cope with a poor system, peopled with poor communicators."*

Health literacy reviews offer a means of focusing organisation-wide attention on improving health literacy. The review undertaken by the DHB discussed above (Hawke's Bay) enabled further work to be planned to begin to address identified shortcomings. Few DHBs, however, appear to have undertaken a similar review.

The revised New Zealand Health Strategy aims for 'people-powered' health services, including actions to *"foster genuine two-way communication between providers and health system users, so that providers have a good understanding of people's needs and aspirations for wellbeing before taking a course of action"*. However, the developing body of knowledge on health literacy shows the first steps must be to ensure all service providers, including SMOs, are equipped with good communication skills, and have good access to training and education opportunities where necessary, as well as suitable opportunities – including time and place – to enable 'genuine two-way communication'.

Engaging with Māori as partners in care

Nāku te rourou, nāu te rourou, ka ora ai te iwi

At a glance

Māori health status remains unequal with non-Māori across almost all chronic and infectious diseases as well as injuries, including suicide.

The underlying causes go back most strongly to colonisation, and loss of land, language and identity. Its effects are expressed as systematic social, political, historical, economic and environmental determinants of health, accumulated during a lifetime and transferred across multiple generations.

Much health inequity is attributable to systemic factors in medical practice. These reflect not only the knowledge, skills and awareness of doctors, but also structural factors in the medical workplace. By developing their cultural competency, doctors can bring about improvements in communication, acceptability of treatment, and success of treatment plans for Māori whānau and thereby improve Māori health outcomes. Such improvements will be enhanced by organisation-wide improvements to achieve health care settings that are culturally safe.

Improvements to cultural competency and safety are a continuing process. Cultural awareness training is not enough in itself. Information components are generally well-received and can be developed over a relatively short period of time, but changing skills, awareness and organisational practice requires ongoing effort and engagement.

While a universal precautions approach to health literacy is important, as discussed in the previous section, it is also important for senior doctors to have regard for the needs and preferences of their patients and to take these into account during communication. This regardful approach to patient centred care is especially significant for improving the health outcomes for service users of different ethnic groups. This discussion focuses on how developing cultural competency can have a positive impact on Māori health outcomes. The discussion is of universal relevance to the medical consultation.

As is well documented, despite improvements in some health outcomes for Māori, disparities remain very evident across many indicators. Māori life expectancy is more than seven years lower than that for non-Māori. Mortality rates are higher for Māori than for non-Māori at nearly all ages. Māori health status remains unequal with non-Māori across almost all chronic and infectious diseases as well as injuries, including suicide. This health inequity is characteristic for indigenous peoples in colonised countries, even when socioeconomic factors are taken into account.[132, 133, 134, 135]

The underlying causes reflect systematic social, political, historical, economic and environmental factors, accumulated during a lifetime and transferred across multiple generations.[136] Senior doctors can bring about change to at least one critical factor – that of poor access to services (‘access’ used in a broad sense).

At the organisational level, access barriers include the timing and availability of services, exclusively

Western approaches to health care, under-representation of Māori in the health professions, appointment systems, the lack of appropriate educational material and disempowerment of whānau in health care settings. At the human resource level, barriers include the characteristics of health staff, including their perceptions of and attitudes about Māori patients, and appropriate provider–patient communication, or lack thereof. At the individual or community level, barriers include the socioeconomic position of many Māori, which makes health care unaffordable, and patient responses to the health care system that is on offer.[137, 138, 139]

To the extent that senior doctors engage with patients with positive intent, there is evidence that misperception and lack of connection between patients from non-dominant ethnic groups and medical professionals is not uncommon. There is also evidence that doctors provide less care to Māori patients than non-Māori patients because of a lack of cultural awareness, latent biases and institutional racism.[141, 142, 143, 144]

There are well-documented differences in health outcomes between Māori and New Zealand Europeans, some of which persist despite adjustment or control for socioeconomic status and demographic variables.

Studies have consistently demonstrated that doctors treat Māori differently from non-Māori, to their detriment. Examples include an analysis of the National Minimum Database over the period 1990–99 which suggests bias against Māori receiving cardiac revascularisation procedures even though the clinical need is much greater. Similar evidence of bias is available for outcomes following stroke, obstetric intervention, heart failure and asthma. Studies in primary care have produced similar findings, where general practitioner consultation times have been found to be shorter with Māori, and they are referred less often to further investigations than non-Māori.[145, 146]

A review to assess literature evidence for disparities in the quality of inpatient hospital care received by Māori found it was not always possible to adequately assess if health care ‘differences’ identified in various studies were in fact health care ‘disparities’ without knowing the impact of other variables. However, the researchers noted:

> *“The methodological inadequacy of an individual study may be a relatively moot point in the context of the body of literature that gives consistent findings, and in which one study, often the more recent study, may overcome the specific failing of a previous investigation.”*

The evidence for disparities in obstetric intervention was particularly consistent and of high quality.[147]

A more recently published six-year study on 89,000 New Zealand public hospital patients found Māori were more likely to be readmitted or to die within a month of leaving hospital than were New Zealand Europeans. After adjusting for age and sex, the odds were 19% higher for Māori. They were 16% higher after adjusting for clinical and hospital variables.[148]

Another recent study shows that significant inequities in timely access to surgical treatment for breast cancer exist, with Māori and Pacific women having to wait longer to access treatment than New Zealand European women. Overall, a high proportion of women did not receive surgical treatment for breast cancer within the guideline limit of 31 days.[149]

And a study examining diagnostic and treatment pathways for Māori and New Zealand European men with prostate cancer found poorer outcomes for Māori men may not only be related to later stage at diagnosis, but differences in treatment modalities may also be a factor.[150]

There is little conclusive information regarding the causes of ethnic health care disparities in New Zealand although, significantly, Māori are more than three times likely to perceive discrimination by health professionals than non-Māori (Table 2). It is likely that multiple factors contribute to health care disparities: the Institute of Medicine in the United States considers that the actions of the health system, the patients, and the providers themselves all have a role.[147, 151, 152]

TABLE 2: SELF-REPORTED EXPERIENCE OF UNFAIR TREATMENT ON THE BASIS OF ETHNICITY, BY GENDER, MĀORI AND NON-MĀORI, 2011/12[151]

INDICATOR	MĀORI			NON-MĀORI		
	Males	Females	Total	Males	Females	Total
Self-reported experience of unfair treatment by a health professional on the basis of ethnicity (ever), 15+ years, percent, 2011/12	3.7 (2.2–5.9)	4.8 (3.7–6.1)	4.2 (3.4–5.3)	0.9 (0.6–1.3)	1.6 (1.3–2.1)	1.3 (1.0–1.5)

There have been no studies identifying differences in the actual interactions Māori and non-Māori patients have with health providers. However, local findings from interviews with Māori patients and clinicians are consistent with international studies, including that:[137, 153]

- patients' attitudes, such as their preferences for treatment, do not vary greatly by race or ethnicity
- there is considerable evidence of unconscious bias, implicit negative attitudes and stereotypes towards ethnic minorities among providers
- these implicit assumptions can result in self-fulfilling prophecies in social interactions, such as consultations with patients
- the time pressures and uncertainties that providers face when assessing patients or making treatment decisions can cause providers to incorporate implicit assumptions into their recommendations.

While it is likely that patients also have corresponding presuppositions about providers, little research has been conducted to date on how patients influence the clinical encounter. A study by the Institute of Medicine suggested that minority patients may perceive bias and therefore avoid care, or convey their mistrust in subtle ways to providers who may misinterpret that attitude and provide less intensive treatment or investigations. The authors concluded that:[134]

> *"Patients' and providers' behaviour and attitudes may therefore influence each other reciprocally, but reflect the attitudes, expectations, and perceptions that each has developed in a context where race and ethnicity are often more salient than these participants are even aware of."*

Cultural misunderstanding and unconscious bias thus contribute to the state of Māori health.

The Medical Council of New Zealand's (MCNZ) approach to addressing this is to improve integration of cultural and clinical competence through recertification and continuing professional development (CPD) processes, including Council-approved programmes which must include audit, peer review and team-based assessments to verify that individual practitioners practise competently and have an understanding and respect of cultural competence.

There is some disquiet regarding the term competency, however – that is, a defined set of knowledge, skills and awareness. Some argue that a culture cannot be learned and that the term implies a finite mastery. But developing 'cultural competency' is intended to be a life-long process, requiring personal growth and commitment. It is about facilitating cultural safety in clinical practice by making practical changes to behaviours and systems, and empowering service users.[154] These attributes are reflected in the MCNZ's definition and longer description of the term, which calls on self-reflection, an openness to ongoing learning, and a willingness to challenge cultural bias wherever it is encountered.[155]

The aims, with respect to Māori service users, are for better outcomes through improvements in

When senior doctors are empowered to design and manage effective systems in their workplace through a system of distributed clinical leadership, patients and staff benefit.

communication, acceptability of treatment, success of treatment plans, and through measurements of doctor performance in delivery of services to Māori whānau.[145]

Some international medical graduates (IMGs), who comprise 43% of the New Zealand specialist workforce (many of whom do not stay for long), may need additional support in successfully developing cultural competency. While some may be more accustomed to working across cultures than their New Zealand counterparts, with potentially positive flow-on effects for their colleagues and patients, others can find transitioning to a new professional environment and operating within and between 'distinct cultural spaces' more challenging.[156, 157, 158]

But how cultural competence is best learned and implemented in clinical settings remains a matter of debate.[140, 159, 160] Māori health models have been used within mainstream and Māori health provider services since the early 1980s in an attempt to address health disparities between Māori and non-Māori. The first of these models to be widely acknowledged was Te Whare Tapa Whā, developed by Mason Durie, based on a traditional Māori approach of wellbeing where the inclusion of taha wairua (spiritual dimension), the role of taha whānau, and the balance of taha hinengaro (mind) are as important as the physical manifestations of illness. Model examples also include Te Wheke, Te Pae Māhutonga, Pōwhiri process and more recently the Meihana model. These models draw on beliefs

embedded in Te Ao Māori to provide a framework for practitioners to tailor their services to Māori patients and whānau.[160, 161, 162]

Critics of cultural competency models, however, argue that they assume homogeneity and encourage an 'us and them' mentality – or perhaps more aptly a 'me and you' mentality.[154, 163]

A higher-level framework, which avoids universal and normative standards, postulates that individuals must possess the cognitive dimension (knowledge), the affective dimension (awareness) and the behavioural dimension (skill) in order to interact effectively with another human being. It has five major components:[154]

- **Cultural desire** – the authentic desire to 'want to' communicate with the other person in a manner that is regardful of their culture, rather than 'have to'.
- **Cultural awareness** – beginning with the ability to reflect on an individual's own culture and in so doing examine cultural values, beliefs and practices in order to reduce the risk of cultural bias, cultural conflicts and the imposition of inappropriate or unethical care.
- **Cultural knowledge** – is defined as the process of seeking and obtaining a sound educational foundation concerning the various narratives of different cultures; acquiring knowledge is a central tenet for the development of cultural competencies.
- **Cultural skill** – exhibiting communication skills across cultural settings.
- **Cultural encounter** – encourages active interaction with others from culturally diverse backgrounds to consolidate, refine and modify existing beliefs and knowledge about particular groups as well as enhance skills in inter-cultural engagements. The value of cultural encounter is also about what can be learned from other cultures and shared for the benefit of all.[164]

Again, these components are reflected in the MCNZ's advice on best practice when providing care for Māori.[165]

Whichever approach is taken by individuals to develop their cultural competency, the literature suggests it is an ongoing process. Information components are generally well-received and can be developed over a relatively short period of time, but changing attitudes and sensitivities requires gradual and progressive engagement and effort – and, importantly, making time for self-reflection. As the MCNZ comments:

> *"It is hoped that Māori specific cultural competencies will be developed in a framework of self-awareness so that doctors will be able to recognise their own values and attitudes, as well as the impact of these on their practices."*[156]

This is taken further in discussion of 'unconscious bias' – that is, unconscious stereotyping associated with different social categories, including ethnicity, age, gender, socioeconomic status and religion – which has been researched for decades but has gained increased attention in recent years. This posits that humans reliably display in-group favouritism (a preference and affinity for their own in-group) and out-group derogation (discrimination towards outgroups), without necessarily being aware of it. This, it is argued, goes at least some way to explaining why, despite New Zealand society's general endorsement of the principles of fairness and equity, disadvantage for Māori endures. Understanding our own biases, and mitigating their impact on our decision-making and interactions with others, is seen as critical to making real progress.[166]

A number of studies have identified interventions for reducing the expression of unconscious bias. These involve visualising or taking part in different scenarios in order to shift perceptions. Another method is to work to 'blur' group divisions rather than reinforce them. Relatively simple measures to foster greater use and visibility of Māori language and culture in the workplace, such as through signage, not only show respect and welcome but may also help to foster positive attitudinal changes generally. (As Māori language has gained visibility in New Zealand society, positive attitudes of New

Zealanders towards the language has increased from 40% in 2000 to 77% in 2009.[167]) Researchers have also found that encouraging critical thinking and moral reasoning more generally helps to reduce bias. A study examining how doctors learn in the workplace suggests the kinds of endeavours needed for developing cultural competence requires protected time, away from the direct demands of patient care, to undertake 'deliberate practice' – a focused effort to reflect and develop performance aspects that need improvement. Hence the importance of full access to time for continuing medical education (CME).

Senior doctors also have an important role in instigating attitudinal change in their workplaces by leading by example in a model of distributive clinical leadership.

Medical practice provides abundant meaningful learning opportunities that could be better utilised by facilitating the conditions for knowledge and skill development. The first priority is to sustain a group climate for learning by encouraging critical thinking, questioning in case of uncertainties, and checking mutual understanding. Management can contribute by initiating work procedures that facilitate these knowledge exchanges, and by identifying recurrent organisational problems in order to improve practices and free up precious time for learning.[168]

The last word

A service user's perspective: excerpts from Cole's Medical Practice in New Zealand 2013

We patients need you, our doctors, to develop a general and interconnected set of attitudes, behaviours, knowledge and skills that enable you, to be nonjudgmental and show us respect and understanding, to be approachable, and to communicate well. We want you to behave in ways that make us feel safe, assist us to ask questions and give feedback about any concerns we have, and we want to be listened to. If our requests cannot be accommodated we want you to be honest with us about why this is. It is helpful when you are friendly, and pronounce our name correctly or at least talk with us so that you can learn how to do this. We appreciate it when you show humility and assist us to tell you if there is any cultural need we may have that you are not aware of. If it is possible, help us to ensure that any important cultural requirements we have are accommodated.

As a general rule we want to be active partners in our health care decision making. However in some cultural contexts we may not want this and we may not find it easy to communicate this to you…

We also need doctors to engage well and in a culturally competent way with our family and other support people when this is appropriate… [and] it is important to remember that each patient context is different and assumptions are never helpful….

General cultural competencies must be recognised as significantly more important than developing a range of cross-cultural knowledge about specific ethnicities and cultures. If you manage to achieve this as well it could be very helpful …. If you are not able or are too busy to meet absolutely all these needs we hope you will help to develop and support health systems that can.

– Jean Hera

From *Cole's Medical Practice in New Zealand 2013,* 'Chapter 4: Cultural competence and patient-centred care'. The full text is available at:
http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.474.2019&rep=rep1&type=pdf

Telemedicine and patient centred care

At a glance

The New Zealand Health Strategy's aim for people to be 'health smart' with information to give them greater control over their health relies heavily on digital technologies, including telemedicine (TM).

A key driver of TM has been its potential to improve access to clinical services that would otherwise be unavailable, especially in rural areas. Another driver has been the need to find a solution to addressing increasing health need within constrained budgets. But despite significant ongoing public and private investment in TM, its value is contested, which in turn has led to a slow uptake.

TM services, when they are thoroughly assessed as being appropriate to the circumstances, and are properly planned and resourced, can complement effective health care delivery, but the available evidence shows they are not a panacea, and the evidence for cost-effectiveness is weak.

A commonly identified critical factor for successful implementation of TM is engagement with the end-users (service users and clinicians) in the appropriateness, design, development and use of the technology.

More investment is needed in carrying out credible evaluations of the potential benefits of TM.

The New Zealand Health Strategy's aim for people to be 'health smart' with information to give them greater control over their health relies heavily on digital technologies. This includes greater use of social media, providing more information via websites and mobile apps, promoting interactive computer games to support good health, strengthening national telehealth services, and creating *"partnerships for better health services by giving everyone involved in a person's care, including the person, access to the same information"* through increasing the use of 'patient portals' (electronic personal health records tethered to institutional electronic health records).

All the above are forms of 'telehealth', a broad term encompassing a range of uses and communication technologies. Discussion in this paper focuses mostly on TM (a subset of 'telehealth', which is often used in the literature interchangeably with 'TM') – defined as *"the use of information and communication technology to deliver clinical services at a distance"*[170] – as this is currently the main area where technology is used (videoconferencing) for direct interactions between specialist and service users, as well as with other clinicians.

A key driver of TM has been its potential to improve access to clinical services that would otherwise be unavailable, especially in rural areas. Another driver has been the need to find a solution to addressing increasing health need within constrained budgets. But despite significant ongoing public and private investment in TM, and despite it being discussed in peer-reviewed literature for over 40 years, its value is contested, which in turn has led to a slow uptake.[171, 172]

Proponents of TM say it has been shown to be clinically effective in some studies, including the management of chronic heart failure and diabetes, and in psychiatry, oncology and stroke services.[171, 173]

TM is also said to be cost-effective, including through reduced hospital admissions, illness prevention and improved patient compliance, satisfaction and quality of life.[174, 175]

Some studies have also shown that patients whose care, education and engagement is supported with telehealth feel more confident and empowered, and experience better patient–provider relationships.[175, 176]

On the other hand, TM can have risks, including possible errors in diagnosis and treatment, and inappropriate testing and prescribing due to the limitations of non-face-to-face consultations. TM may also lead to depersonalisation of the patient–doctor relationship and continuity of care.[176, 177]

Disruption to doctors' workflow brought about by the demands of TM can have a negative effect on work satisfaction, and some studies show workload can increase and add to doctor burnout rates.[177]

In the view of some researchers, despite TM being the subject of many published papers over many years, "the evidence base for its use is weak" due to the shortcoming of TM research and implementation.[172, 178, 179]

A Cochrane review, which included 93 trials synthesised over 500 pages, says TM has the potential to be effective in delivering more frequent and timely health care to people with chronic conditions at a distance, and for improving access to health care. However, it concludes:

> *"The evidence base for the cost-effectiveness of [TM] monitoring strategies to improve outcomes or reduce the need of face-to-face consultations is limited, future research should plan to address this by designing cost-effectiveness studies alongside studies of effectiveness. Pragmatic studies over multiple sites are also needed to show that individual site set-up costs are low enough to make the overall strategy cost-effective. Evidence on the acceptability to both patients and health professionals is also limited, future studies should attempt to capture patients views and assess how TM fits within a local health system."*[171]

In addition, the Cochrane review found it was not possible to draw any conclusions from the studies reviewed about how the use of TM may affect professional practice. *"A high refusal and drop-out rate in the telehealth groups in several studies suggest that in some circumstances TM was not acceptable."* Reasons for participants withdrawing were associated with failure to transmit data. Few studies assessed patient satisfaction with the delivery of care. Few of the studies included in the review reported data on unintended consequences, and *"further evidence is required from implementation studies".*

A Cochrane editorial, following the review, commented:

> *"…it is difficult not to be discouraged by the [review's] modest conclusion: that interactive TM can lead to similar health outcomes as face-to-face delivery of care, but the cost to a health service and acceptability by patients and healthcare professionals is not clear".*[180]

The editorial notes the low take-up of interactive TM.

> *"The reasons behind slow adoption are a matter of debate, but the lack (real or perceived) of clear evidence about its benefits, costs, and acceptability plays an important role."*

The point is underscored in a study examining the factors facilitating or blocking the implementation and diffusion of process-based health care innovations generally.[181]

> *"Within certain professional groups, most notably clinicians, 'hard' evidence which would be obtained from scientific methods was construed as the necessary prerequisite for the demonstration of the innovation impact, without which any persuasive effort was doomed to failure. Anecdotal or experiential testimonies were unable to exert any significant influence; scientific data were seen as the only basis for a process*

> *of persuasion, and on which prospective adopters could make informed decisions."*

A 'hype cycle' can occur where inflated expectations of TM promoted by commercial interests and enthusiastic policymakers do not fulfil their promise in the anticipated timeframe, and which in turn can lead to a 'trough of disillusionment'.[182]

Similar observations are made in a study which identifies conflicting discourses on TM, the most common of which – the 'modernist discourse', which largely reflects that of policymakers and the technology industry – is typically futuristic and utopian, depicting technology as offering reliable, cost-saving and ethically benign solutions to increasing health service pressures.[173]

> *"Imaginary future scenarios of the 'smart home' (spacious, clean, connected, safe, watched-over and free of technical or emotional trouble) and digitally empowered older citizen (literate, skilled, technically and socially engaged and with high quality of life despite having illnesses in need of monitoring) were common."*

'Empowerment' is equated in this discourse with compliant use of information technologies.

> *"Through 'persuasive technologies' (defined as 'a computing system, device, or application intentionally designed to change a person's attitude or behaviour in a predetermined way'), medical intervention would be possible at an increasingly earlier stage in the chronic disease process, allowing the person (assumed to be a rational actor) the opportunity to 'choose' a healthier lifestyle."*

> *"Technological and human infrastructures were depicted, like the technologies themselves, as ubiquitous, error-free, 'automatic' and always available."*

This 'modernist' perspective, however, conflicted with other less-prominent discourses, including the 'humanist' discourse (reflecting the views of social scientists and related academic disciplines), which is typically person-centred, small scale, and grounded in present reality, and the 'political economy' discourse (including the views of critical academics and sceptical clinicians), which questions the 'efficiency narrative' and suggests policies emphasising the use of TM are shifting towards a commodification of health care.

For the potential benefits of TM to be realised, more emphasis must be placed on understanding the role, feasibility, efficacy, clinical effectiveness and economics of using the technology.[172]

> *"When telemedicine is implemented to solve a poorly understood problem, or when it is driven by technology rather than the clinical problem, then success, or even the ability to assess success, may be predicated largely on luck…."*

> *"For telemedicine to improve access and/or control costs, it is essential to understand a priori how it is expected to help; that is, for which patients, which clinical problems and in which settings. It is also important to consider how telemedicine will dovetail with conventional health service delivery, organisation and funding, and fit in with the practice and referral preferences of clinicians. This understanding should go beyond anecdotes; determining whether telemedicine is an appropriate response to a particular set of circumstances should be evidence-based."*

A commonly stated aim of TM is that it becomes fully integrated into current clinical practice and that it should, at a minimum, meet all the standards of traditional face-to-face encounters. (The Medical Council of New Zealand sets out the requirements in its *Statement on Telehealth.*[183]) At the same time, however, the use of TM also usually means changing current practices. It may require, for example, greater integration with other services, establishing new roles within the clinical team, reorganising workflows, increasing staff capacity where there is increased service user communication, accessing ongoing training in the new (and constantly changing) technology, managing an increasing volume of electronic data, and undertaking ongoing monitoring and evaluation. Further, the circumstances, capacity and attitudes of individual service users must be taken into account to assess whether TM is appropriate for them. All of which have implications for clinicians' time and resources, especially in metropolitan specialist services that are providing increased volumes of consultations for provincial service users as well as those locally.

> *"Underestimating the additional resourcing required to support implementation, particularly in the establishment phase, has been identified as a common cause of telehealth failure, in particular, the under-estimation of the personnel requirements."*[184]

> *"Sufficient human and financial resources were of paramount importance not only for the proper implementation of service innovations but also for their diffusion to other organisations, sectors and fields of practice."*[181]

Not least, as discussed above, clinicians want to see the evidence for TM's service-user outcomes and its cost-effectiveness.

For these reasons a commonly identified critical factor for successful implementation of TM is engagement with the end-users (service users and clinicians) in the design, development and use of the technology.[185]

> *"For new technologies to succeed, they must accommodate a spectrum of user needs. Technology must engage patients in their care and enhance collaboration with the health care system or they are destined to fail."*[186]

> *"Experts in the field do not consider that telemonitoring has achieved a good fit with the life world of patients nor into the professional, organisational procedures of health service delivery systems."*[184]

Drawing on the literature identifying critical success factors for establishing and sustaining a TM service – in particular, a Victorian (Australia) Department of Health and Human Services publication on the topic – the range of commonly identified factors for effective and sustainable TM services are summarised in Table 3.[184]

A range of resources are available through the advisory group the New Zealand Telehealth Forum, including links to detailed guidelines for establishing and maintaining TM services in New Zealand. They take into account the factors identified in Table 3, as well as providing practical matters such as scheduled and unscheduled consultations, consultation locations, room set-up, informed consent and prescribing.[187]

In a stocktake of DHB telehealth services in 2014, the New Zealand Telehealth Forum found progress was being made, but there was a long way to go to realise the full potential benefits of telehealth technologies. It noted the risk that:

> *"If the total cost of ownership in providing a telehealth-enabled service isn't adequately planned for, clinically supported, and appropriately resourced, it won't be sustainable."*

> *"If greater progress is to be made in the adoption of telehealth, it is vital that there is real investment in carrying out credible evaluations of the healthcare and financial benefits that arise from its effective use. This will enable the investment cases to be made on hard data rather than merely through the aspirational thinking and leadership of individuals."*[188]

Patient and staff experiences are inextricably intertwined, so to approach patient centred care as exclusively about patients is to overlook a critical piece of the puzzle.

TABLE 3: FACTORS FOR SUCCESSFUL TELEMEDICINE

FACTORS	Features include:
A clear purpose has been established	• Identifying the clinical problem to be solved using TM, the anticipated outcomes and how they will be measured, based on evidence of TM used in similar contexts.
There is strong clinical leadership	• Having strong support from senior management and all clinicians involved in the TM service, with 'champions' identified and a highly skilled project leader.
Clinicians and service users recognise the benefits and are engaged	• Involving clinical staff in developing the project plan and the evaluation measures. • Consulting service users in designing the service. • Establishing regular lines of communication to keep all parties informed of progress, with feedback mechanisms for staff and service users.
Project planning informs implementation	• Assessing the capacity for organisational, clinician and consumer adoption of TM. • Assessing community health needs.
Technology and clinical service needs are well matched	• Establishing that the proposed clinical service lends itself to a TM service. • Seeking advice on the types of available technologies and assessing which is most suitable, including user-friendliness. • Assessing whether the proposed technology is interoperable with end sites, including sites in other relevant organisations. • Establishing responsibility for troubleshooting technical problems.
Privacy	• The technology and the end-point facilities are such that privacy and security of information are assured.
A sustainable workforce model underpins the service	• Establishing an adequate workforce base to support the demand for TM services. • Securing the necessary technical and administrative resources. • Developing mechanisms to monitor and manage any additional impacts on the health service or clinicians.
Change management is a focus	• Establishing targeted training programmes for clinicians. • Ensuring staff remain fully competent in the use of the technology over time. • Assessing the impact of TM on clinical and administrative processes, and planning accordingly. • Developing a change management plan, including how the changes will be sustained.
Clinical responsibility and governance protocols have been clearly articulated	• Developing clinical protocols to guide the use of TM across the organisation. • Establishing responsibility for adherence to the protocols, and governance.
A sustainable funding model is in place	• Analysing costs and risks to create a sustainable business model.
Services are patient centred, and service users are supported in using TM	• Assessing end-users' technological capability and acceptance of technologies. • Assessing cultural responsiveness in the design of the service and technology. • Training and support are provided to assist end-users in using the TM service.
There is ongoing review and evaluation	• Identifying the relevant data to be captured. • Establishing baseline measures. • Developing a system to report results back to the organisation and the sector.

Source: Department of Health and Human Services, Victoria 2015

Making time for patient centred care

At a glance

Patient centredness is not a checklist, a dashboard or an action plan. The literature describes it as 'a cultural transformation'. It is about engaging the hearts and minds of the entire organisation's workforce, not least senior doctors, whose interactions with patients and their families lie at the heart of patient centred care.

It is critical that the workplace environment is conducive to achieving genuine patient centred care, recognising that patient centred care and health professional care are two sides of the same coin. Poor work environments contribute to stress and burnout, staff turnover and medical errors; positive work environments promote high quality care and cost efficiency, and a more stable workforce.

Priorities, with respect to the SMO workforce, are:

- addressing entrenched SMO shortages
- implementing measures to reduce stress and SMO burnout, and create safe and health workplaces
- genuine commitment to establishing distributed clinical leadership throughout the system
- establishing staffing levels that ensure SMOs have proper access to continuing medical education and time for clinical leadership.

Some government policies have posed barriers to creating the conditions for patient centred care. Policies and priorities need to be better aligned to support them.

To succeed, a patient centred approach must also address the staff experience, as staff's ability and inclination to effectively care for patients is unquestionably compromised if they do not feel cared for themselves.[189]

If health care organisations want to become patient centred, they must create and nurture an environment in which their most important asset – their workforce – is valued and treated with the same level of dignity and respect that the organisation expects its employees to provide to patients and families.[190]

High quality patient centred care in New Zealand requires commitment across the whole spectrum of the health system, from the clinics and wards to the boardrooms and the Beehive. Being truly patient centred, where patients and their families are able to engage as effective partners at every level, is a continuous path rather than a destination. Developing and sustaining a patient centred culture across the whole systems requires adaptability and flexibility to meet the needs and expectations of patients, families and staff – needs that will inevitably evolve over time.[190]

Discrete patient centred care programmes, on their own, may address specific objectives, but they will fall short of cultivating an authentically patient centred organisation. Patient centredness

is not a checklist, a dashboard or an action plan. The literature describes it more as 'a cultural transformation'. A culture of patient centred care is characterised by the core values and attitudes behind the implementation of such programmes. It is about engaging the hearts and minds of the entire organisation's workforce, not least senior doctors, whose interactions with patients and their families lie at the heart of patient centred care.[190]

It is critical, therefore, for health service management to demonstrate a strong and long-term commitment to ensuring the workplace environment is conducive to achieving genuine patient centred care, recognising also the broad consensus in the literature that patient centred care and health professional care are two sides of the same coin. Poor work environments contribute to stress and burnout, staff turnover and medical errors; positive work environments promote high quality care and cost efficiency, and a more stable workforce.[191]

Many countries are facing the challenges of creating and maintaining good quality work environments in rapidly changing health systems that are increasingly strained due to funding constraints and inadequate health workforces. New Zealand is no exception.

Given the complexity of work environment issues, policies to achieve high quality working conditions need to be multidimensional and inclusive. Because effective solutions are context-related, priority has to be given to improving conditions at the 'front line' of service delivery, supported by management, which in turn requires the support of government policy and resources.[192]

In New Zealand the immediate task is to address specialist workforce shortages. New Zealand faces a steeper challenge than most other countries in the Organisation for Economic Co-operation and Development (OECD), where it ranks poorly on the number of specialists per population.[192]

Addressing entrenched specialist shortages

Long-term specialist shortages have been acknowledged by Health Workforce New Zealand as impacting on the *"workloads, wellbeing and productivity of DHB-employed senior doctors"*.[193] While the DHB specialist workforce has been growing, the net growth rate (approximately 175 on average over the past five years)[194] is well short of what is needed to both address long-standing shortages and meet increasing health needs of a growing and aging population.

To achieve parity with Australia's projected specialist workforce per population by 2021, for example (a modest target given Australia's figures are below the OECD average), DHBs require an estimated net growth of 300 specialists per year. That figure would be a net growth of approximately 380 specialists a year to reach the required workforce level indicated by the surveys of DHB heads of department and taking into account the effects of demographic changes.

The effects of continuing shortages on the health and wellbeing of SMOs is well documented in two recent national surveys of SMOs. The first, published in November 2015, found many DHB-employed SMOs routinely go to work when they are ill. The main reasons for doing so include SMOs not wanting to let their patients down and not wanting to over-burden colleagues. The second study, assessing the extent of fatigue and burnout in the SMO workforce, published in August 2016, found 50% of respondents reporting symptoms of burnout.[89, 90]

Addressing shortages as a top priority is needed not only to improve the health, wellbeing and morale of staff, recognising patient centre care requires the nurturing of staff as well as patients, but also to establish sufficient workforce capacity to deliver patient centred care, recognising patient centred care requires specialists to find more time to engage with patients and families. Specialists also need more time for all the activities that contribute to good patient centred care, including multidisciplinary teamwork, delivering better integrated care, distributive leadership and ongoing skills training and education, on top of increasing clinical workloads.[195]

Increasing the specialist workforce capacity depends of course on improving retention and recruitment. While New Zealand already relies heavily on IMGs, with IMGs comprising 43% of the total specialist workforce (and 47% of the DHB full-time equivalent specialist workforce), building workforce capacity will require a continuing influx of IMGs for the foreseeable future. However, Medical Council of New Zealand (MCNZ) data shows they have poorer retention rates than New Zealand trained doctors.

Given the importance of retaining IMGs, there is surprisingly little research available to guide policy responses. What is available suggests key issues include remuneration, and barriers for partners and family to settle in New Zealand. That the demand for doctors is becoming increasingly competitive internationally should add further impetus to efforts to create more attractive work environments in our health services, including more welcoming approaches to doctors' families.[80, 196]

Addressing specialist workforce shortages is a prerequisite for addressing other 'quality of workplace' issues discussed below.

Reducing stress and improving work–life balance

Improving retention among older specialists is becoming more critical as many are nearing the traditional retirement age, raising concerns that this will exacerbate existing shortages. Strategies identified for improving retention include intervention to reduce stress, changing work roles, introducing more part-time and job-share positions, and more flexibility in work hours.[197]

The growing number of women in the workforce, here and internationally, is adding to the challenges posed by an aging specialist workforce. MCNZ and Census data show women tend to work fewer hours than men. In 2014, women comprised 31% of the specialist workforce, compared with 19% in 2000.[198]

As this trend continues, the projected specialist headcounts required to ensure a viable and secure workforce will need to be adjusted upwards to achieve the same number of full-time equivalents.[199]

In addition, a growing desire for a better work–life balance generally is likely to have a similar impact on workforce supply over the next decade. One Australian survey indicated 81% of hospital doctors want greater access to flexible working arrangements to allow them to spend more time with family and friends, or continue further formal training. The work–life balance factor is now a common draw-card in advertisements for medical positions.[200, 201]

Promoting safe and healthy workplaces

An extensive and growing international body of evidence shows fatigue in doctors – found to be highly prevalent in New Zealand DHBs[89] – contributes to reduced wellbeing, reduced quality of care and increased errors and accidents.

In response, the Australian Medical Association (AMA), with the support of the Federal Government, has produced a *National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors*, which applies to all hospital employers and salaried hospital doctors. It was prepared in recognition of the responsibilities of employers and employees under occupational health and safety legislation, which is similar to New Zealand's occupational health law.

The code is one part of a broader education and awareness programme to change a culture that supports long working hours and unhealthy work patterns.

The scope of the code is limited to hazards related to shiftwork and extended working hours and the effect on the health and safety of individual doctors and impacts on patient care. Because the level of fatigue and the consequent effect on safety and work performance is complicated and is the product of a range of factors, the code does not contain absolute, enforceable limits on single elements such as the maximum length of a safe shift or the break required between episodes of work. Instead, the code contains a *Risk Assessment Guide* and a *Risk Assessment Checklist* to help identify fatigue factors and assess the risk level of an individual's working hours. It then provides the tools to reduce the identified risk levels. The model is essentially: hazard identification, risk assessment and risk control.

This is a voluntary code. It does not have evidentiary status but has legal status like all other guidance in that it contributes to 'the state of knowledge' about a particular hazard or risk and the ways of mitigating that hazard or risk. It provides recommendations for duty holders to consider in meeting their legal obligations.

Also, to be effective, a broader strategy is needed, including – in the AMA's words – *"an education and awareness programme to change the current individual and organisational beliefs and culture that support working hours and patterns that would be considered unacceptable in most other industry sectors".*

The recent ASMS survey on the prevalence and level of fatigue in senior doctors in New Zealand points to an urgent need for an effective policy response from DHB management, which the ASMS is currently pursuing.

Continuing professional development

Patient centred organisations focus on increasing their staff skills to support patient centred care delivery. Strategies to achieve this include continuing professional development in communication skills, and holding education sessions for health care professionals where patients and families share their experience of care.[202]

While communication skills training improves patient–doctor communication, the improved behaviour can lapse over time, so it is important to practise new skills with regular feedback on the acquired behaviour.[26] Furthermore, the rising complexity of care trajectories, due to the growing numbers of chronically ill patients, further increases the communication demands facing clinicians, requiring increasingly sophisticated kinds of communication amidst complexity.[23]

Research findings demonstrate that effective communication heals, and that sub-standard communication can adversely affect patient care. Paying close attention to what defines effective patient–clinician communication in a complex and constantly changing environment is therefore critical to the quality and safety of contemporary health care. It is an important part of specialists' continuing professional development, which the MCNZ requires of all practising doctors in order to be issued with a practising certificate each year in line with the requirements of the Health Practitioners Competence Assurance Act 2003.

Specialists are also urged to use their continuing professional development to develop and maintain cultural competency.[203] Under the Health Practitioners Competence Assurance Act, the MCNZ requires doctors to show they are culturally competent by demonstrating the appropriate attitudes, awareness, knowledge and skills towards their patients irrespective of the patients' cultural background. Cultural competency includes not only ethnicity but also matters *"…related to gender, spiritual beliefs, sexual orientation, lifestyle, beliefs, age, social status or perceived economic worth"*.[155]

Māori and Pacifica health status indicators alone underscore the importance of cultural competence. This is emphasised further by New Zealand's heavy reliance on IMGs.

A memorandum of understanding between the MCNZ and DHBs includes, among other matters, the requirement that DHBs shall:

- provide an environment which supports learning and development and which allows DHB-employed doctors to fulfil their recertification and accreditation requirements
- ensure collegial relationship arrangements are in place and that doctors have access to continuing professional development resources.[204]

Despite the memorandum of understanding, emerging evidence that many specialists are unable to access appropriate levels of non-clinical time to undertake activities such as continuing professional development further indicates the urgent need to address specialist shortages.[196]

Promoting clinical leadership

Effective clinical leadership is another key factor in achieving patient centred care.[24, 52, 74] There are a number of reasons for this.

First, as has been found in Britain's NHS, the command and control, 'pace-setting' leadership style – otherwise known as 'managerialism' – is incapable of accommodating the complexities of a more participative, supportive environment that is required for patient centred care.[205, 206]

The need for service-specific knowledge – understanding how clinical services work and what is required to provide high-quality care – means clinicians need to be among the people leading the change.

The practicalities of improving health care require activity right across the system, involving the whole spectrum of health care professionals. In exceptional organisations leadership for improvement involves reforming the system through a sustained effort, often over many years. This effort is designed to create the ways of working, people development, culture, systems and environment that are the conditions for promoting improvement.[207]

Patient and staff experiences are inextricably intertwined. Consequently, to approach patient centred care as exclusively about the patient and family is to overlook a critical piece of the puzzle. The insights of staff, at the clinical team level, provide critical intelligence for how to foster an environment that is nurturing not only for patients and families but also for health care professionals.[52, 190]

Involving senior doctors directly in the design and implementation of patient centred processes is an important way to achieve engagement, improve the efficiency and quality of services, increase patient and staff satisfaction, improve safety, and reduce staff turnover.[191, 207]

Studies on the effects of engagement have consistently shown that improvement in health care is a cultural phenomenon that relies upon the contribution of staff who are not only individually motivated but are also provided with the appropriate time and opportunities to apply their skills, knowledge, and experience.

A 'medical engagement scale' developed for the NHS to assess the effects of management and organisational systems on doctors' engagement has three aspects: working in an open culture; having purpose and direction; and feeling valued and empowered. Data from almost 30 hospitals using the scale revealed a strong association between medical engagement and performance measured by the Care Quality Commission.[208]

A related study by the NHS Institute and the Academy of Royal Medical Colleges identified the lessons from seven NHS organisations with the highest levels of medical engagement. All acknowledged it took time and was often challenging, and disengagement could be sudden and precipitous. But they highlighted consistent benefits such as successful initiatives, innovation, staff satisfaction and retention, improved organisational performance and better patient outcomes. The organisations emphasised that engagement should be persistent and reach the entire medical workforce, not just those at the top.[209]

The benefits of engagement are mirrored in numerous studies on clinical leadership in general. There is now a strong consensus internationally that collective or distributed clinical leadership is the required model to meet the challenges facing health care systems around the world.

Support from management and government

The New Zealand Government has acknowledged the importance of engagement, broadly, and clinical leadership specifically through several policy documents, and, until recently, implementing clinical leadership was signalled as a high priority in the Minister of Health's annual 'Letter of Expectations' to DHBs.

Surveys of senior doctors about the extent to which clinical leadership is being implemented by DHBs, however, indicated a major fault-line between policy intent and policy in practice.[81]

Commitment from management and, in turn, government from the outset is critical for any major new policy to find traction. Staff in many hospitals have become accustomed to, and often disillusioned by, 'flavour of the month' initiatives that are launched with much fanfare only to disappear when results do not materialise as expected.[190]

With less weight given to the importance of clinical leadership in the Minister's 'Letter of Expectations' to DHBs for 2017/18, and its omission from the recently updated New Zealand Health Strategy, the previous Government's position on clinical leadership appears to have changed from being a 'fundamental driver of better health services' to a theoretical 'nice to have'. Unless concerted commitment is shown by DHB management and the new Government to distributed clinical leadership, which is a critical component of patient centred care, the latter is in danger of also being relegated to a 'nice to have'.

It may be that DHB management's poor record in implementing distributed clinical leadership is due at least in part to continuing financial constraint forcing a focus on short-term decision-making, but broader government health policy priorities may also be cutting across longer-term strategic policies such as clinical leadership and patient centred care.

A study on leadership styles in the NHS identifies the dominant approach as typified by laying down demanding targets, leading from the front, often being reluctant to delegate, and collaborating little – and is the consequence of the health service focusing on process targets, with recognition and reward dependent on meeting them.[210, 211] Such an approach will be familiar to many working in New Zealand's public health system.

Targets in the NHS, as in New Zealand, may have helped to increase elective surgery volumes (though not sufficient to meet evident growing unmet need) and bring about faster treatment in emergency departments. However, they have done so at the cost of a dominating top-down leadership approach to the exclusion of other leadership styles, such as 'affiliative' – creating trust and harmony – or 'coaching'.[52]

As a former senior government health official has commented:

> *"…ministers from successive governments have become besotted with targets – technology has enabled ministerial insight into the very heart of health services, and offers the opportunity to micro-manage these interactions like never before. This is truly transforming the system, but not in the way you might imagine. Technology, and its enabling of the use of precise targets, has narrowed the decision space of district health boards to the point that they are losing a sense of oversight of the sector at the local level, losing their focus on equity, and are redefining themselves as, in the words of Capital and Coast DHB, 'An organisation configured to achieve health targets.'"*[212]

If patient centred care, as the literature indicates, requires a cultural transformation across health care organisations, the evidence also suggests government policies and priorities need to be better aligned to support such change instead of impeding it.

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