



THEME

Quality framework



Patient focus and the quality framework

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BACKGROUND

The Royal Australian College of General Practitioners Quality Framework for Australian General Practice provides a mechanism for planning and assessing quality improvement initiatives in an Australian context that takes account of the perspective of patients in the health care system.

OBJECTIVE

This article examines the patient focus domain of the quality framework.

DISCUSSION

The quality framework is applied to the patient focus domain using examples such as the patient centred model of the consultation, consumer expectations of the general practice of the future, and health inequalities and the role of general practice.

'Nothing about us, without us'. This long standing motto of the international disability rights movement also encapsulates the wishes of patients – the consumers within the health care system – to participate fully in enhancing the quality of the system at all levels:

- as active partners in the consultation
- as customers of the setting of care
- as the population of a region whose collective health is dependent on the services of the region, and
- as the consumers, community members and taxpayers who have a legitimate stake in the health systems of the country.

It is self evident that patients are at the centre of health care, particularly in general practice where outcomes depend so much on patient self care. The World Organisation of Family Doctors (WONCA) emphasises patient preference in defining quality.¹ As a consequence, efforts for quality improvement in general practice will be inadequate without a focus on the patient as both participant and consumer.

This article examines the patient focus domain of The Royal Australian College of General Practitioners (RACGP) quality framework in three settings: the patient centred approach to the consultation; consumer expectations

of the general practice of the future; and the impact of health inequalities in populations and the capacity for improvement in general practice at the national policy level.

Patient centredness in the consultation

McWhinney describes the essence of the patient centred clinical method as being: '...the physician's attempt to fulfil a twofold task: understanding the patient and understanding his or her disease. From this understanding flows the process of management for both patient and disease'.²

In its landmark review 'Crossing the quality chasm', The Committee on the Quality of Health Care in America identified patient centeredness as one of 'six aims for improvement to address key dimensions in which today's health care system functions at far lower levels than it can and should'.³ The World Health Organisation listed patient centred care as one of 5 core competencies for preparing the 21st century global health care workforce.⁴ In Australia, the National Health and Medical Research Council has produced a resource to help improve communication between health professionals and consumers⁵ as a fundamental requirement for evidence based health care.⁶

Stewart et al⁷ report that 'patient centred encounters

result in: the duration of the office visit remaining the same, better patient satisfaction, higher physician satisfaction, and fewer malpractice complaints' and that 'patient centered practice improved health status and increased the efficiency of care by reducing diagnostic tests and referrals'.

Stewart et al⁹ have developed a patient centred model for clinical care (*Figure 1*). It has six interacting components:

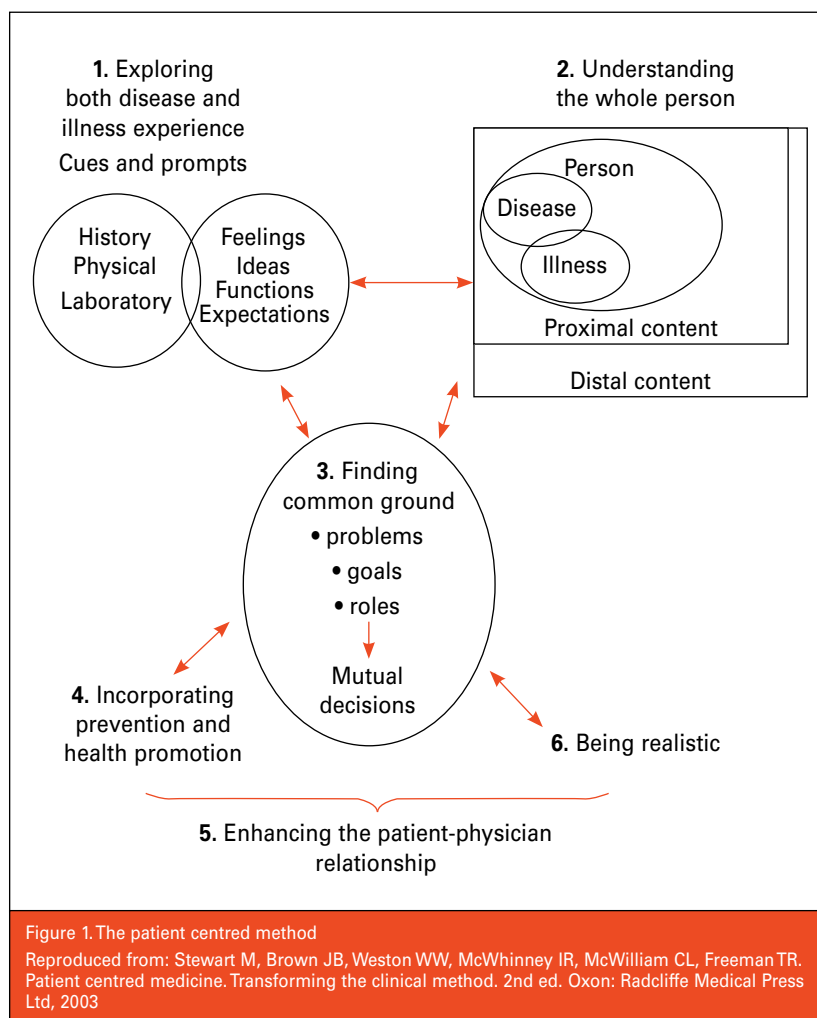
- exploring both disease and illness experience, using the traditional medical approach of history and examination enhanced by exploration of the patient's experience of illness – feelings, impact, and expectations
- understanding the whole person, being aware of the complex facets of the patient's life
- finding common ground with the patient by mutual exploration and negotiation to define the problem, establish goals for management and identify who will do what
- incorporating prevention and health promotion, taking advantage of the opportunity present in each consultation
- enhancing the patient-physician relationship to ensure an ongoing trustful, sharing, and healing relationship, and
- being realistic about time, resources, and the working of the health care team.

Consumer expectations of general practice

Such a patient centred approach is very much in line with expectations of many patients who already seek and value it, and will do so increasingly. For example, in a review of 19 studies of patients' priorities in primary health care undertaken between 1965 and 1996, three of the top four most common patient priorities were: 'humaneness' (86%), 'patient involvement in decisions' (63%) and 'time for care' (60%).⁹ 'Competency and accuracy' was ranked second at 68%. This humaneness includes not only the ability to listen but also crucially the ability to relate to and engage with the patient's agenda and values. Australian doctors often rate very highly on the first, but do less well on the second component.¹⁰ Communication and empathy are clearly at the heart of such an approach.

Not only do patients increasingly expect to be involved in decision making in their own care, but governments, the courts, health services and accreditation bodies all now expect it as core part of the care approach.^{11–13}

There is also emerging evidence of the effectiveness of patient focus. Recent Cochrane reviews found that the use of decision aids to involve the patient closely in



decision making about their own care not only increases patient understanding and satisfaction but leads to better health outcomes.¹⁴

A patient focus also enables the clinician to see the patient in his or her own context. Patients are as varied as the Australian population, by definition, and they have vastly different demographic and genetic characteristics, lifestyles and environments, cultural backgrounds, and values and beliefs about health. A good therapeutic relationship needs to be based on a real understanding of each patient.

Health inequalities and the role of general practice

Despite marked improvements in health care and outcomes over the past 50 years, 15–20% of the burden of disease can be attributed to avoidable socioeconomic inequalities in health.¹⁵ This is equivalent to the burden of disease attributable to lifestyle risk factors such as smoking, nutrition, alcohol, and physical activity.

Equity is frequently seen as a component of quality, and this concept is incorporated in the quality framework

definition of quality as the dimensions of accessibility and appropriateness. From the patient focus perspective, it is important to consider whether the benefits of any quality improvement effort could be distorted by 'the inverse care law' – where medical care is least likely to reach those most in need.¹⁶ It will always be important to look at proposed quality improvement activities through an equity screen, whether at the setting of care, regional or national level. Important questions will be:

- what is this improvement project or policy trying to do
- which groups of patients will most easily benefit, and which might miss out
- are there likely to be unexpected consequences
- what adjustments might ensure those who most need improved care receive it, without the quality improvement equivalent of adverse events?

Conclusion

Quality improvement efforts require a thoughtful focus on patients at all levels. How have consumer views been incorporated into national policy formulation? How have patients' situation and preferences been incorporated into this model of general practice care? Who might not benefit from this quality initiative? How successfully do we find common ground with patients in the consultation and with consumers in the wider general practice system?

Conflict of interest: none declared.

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