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Patient-Centered Care; Physicians' View of Obstacles against and Ideas for Implementation

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ABSTRACT

To implement proper family medicine practice and to get the best of it, the concept of patient-centered care (PCC) has to be put into use. Studies have found that one of the most important advantages of PCC is the increase in the patients' quality of life. PCC has been recognized as a marker of quality in health service delivery with its improvement. However, the physicians' belief is essential for its implementation. A cross-sectional study was done to find out what family physicians think of PCC and what they believe are the obstacles that block from its use in Bahrain. Twenty-eight family physicians (FPs) working in the primary health care centers were arbitrarily culled from a pool of doctors. To all a pre-designed questionnaire was sent that contained three parts; demographic information, type of facilities that they work and whether it is promoting PCC practice and the last was concerned with the physicians' view about the barrier against its implementation and what they cerebrate that could avail in promoting it. The results showed that the majority of the participants were family physicians working in governmental health centers. More than 85% knew the congruous definition of PCC and 96.4% thought that the most common barrier for not implementing PCC approach is the time constraint while almost 93% thought that the short duration of time of the consultation is another impediment for implementing PCC. Withal, 57.1% and 53.6% of FPs thought that language and the doctor's communication skills are other barriers respectively. Since the ultimate aim of provision of health care in any country is the optimal health of the population and since PCC practice could fortify and avail in achieving that goal, it is recommended that policy makers and health authorities are required to abstract all obstacles that works against implementing PCC and change the work environment in order to make it facile for the practitioners to apply PCC practice approach.

Key words: Patient centered care, Primary Care Centers, Family Physicians, Barriers, Obstacles.

List of abbreviations:
PCC: Patient Centered Care
FPs: Family Physicians
PHC: Primary Health Care

INTRODUCTION

PCC is the health care that is provided to patients after furnishing them with full detailed explanation of their illnesses and giving them a chance for deciding about their management plans with their full autonomy. It is also the practice where the patients are not seen as a group of diseases, but as a human being that have sets of feelings and emotion, complaining of physical problem. Hence, it moves the concentration from only body care priority to a total care. However, to practice this model of care, certain requirements are needed which are mainly related to three factors; the health facility, the physician, and the patient. The health care facility should provide the proper environment for the implementation of PCC, such as appropriate consultation time, encouragement by the policy

makers, supportive surroundings (colleagues and logistics) as well as ongoing continuing education for this concept. Shallerin 2007 recognized the consequentiality of employing, teaching, assessing, rewarding and fortifying employees committed to PCC[1]. While the most important ingredient in the physician that helps PCC is the doctors' believe in this model of care. They also should develop the knowledge and skills that are needed in PCC. With regard to the patients, they have to be educated about the benefits of this model of care. In 2005, Saultz and Lochner have shown that patients who consult the same physician have better results, better preventive care, and less time spent in hospital[2]. Within the PCC approach the patient's view is very well respected and be allowed to share in the decision making process[3]. The doctor has to deal with the patient as a human being who has an illness and not vice versa[4]. PCC also helps to develop and strengthen the relationship that bounds both the patients and the physicians together. A relationship that depends on mutual respect and shared decision that helps in a better solving approach to the patient's problem. Moreover, PCC helps in better diagnosis and decreases the utilization of diagnostic tests, prescriptions, hospitalizations, and referrals[5]. Ponte et al., 2003 in highlighting its importance quoted that PCC is "A way of viewing health and illness that affects a person's general well-being and an attempt to empower the patient by expanding his or her role in their health care"[4].

MATERIALS AND METHODS

This is a cross-sectional descriptive study that was done on a randomly selected twenty-eight physicians to explore their views and knowledge about PCC and to find out what they thoughts are the obstacles against its full implementation.

Most were certified FPs working in the 25 primary health care centers that are distributed in the Kingdom of Bahrain.

A pre-structured questionnaire that was used in an earlier study[6] was used after few amendments with the author's permission. The questionnaire consisted of three areas of information that are related to; demographic characteristics, description of the health care facility; and the last part is concerned with the obstacles against and views for PCC implementation.

After orientation, the sample's permission was granted to be included in the study. The questionnaire was distributed to all the physicians, and they were asked to complete and send it back to the authors. Data was entered and analyzed using the SPPS statistical package version 20. Descriptive analysis was conducted by obtaining the frequencies and percentage of all variables. Since the number of participants in the study is not large and the number of frequencies in some of the cells is very small, Fisher exact test was used to measure the association between obstacles against implementing PCC and the health facilities with participants' characteristics. P-value less than 0.05 were considered statistically significant.

RESULTS

Twenty-eight physicians included in the study. Their ages ranged from 25 to 56 years and 21 (75%) were female. All have completed one year of internship after graduation, and almost all had their postgraduate training except one who did not pursue further training. The Majority, 17 (73.9%) were trained for more than three years either in Bahrain or overseas countries. Almost all attend regularly continuous medical education programs.

When asked about the average duration of time spent in a consultation, the majority 24(85.7%) spend from 5 to 10 minutes while only 4 had consultations for more than 10 minutes. Twenty-five FPs (92.6%) stated that they see 25 or more patients during any working shift (Table1).

Table 1: Participants, characteristics

Variable	Number (n=28)	%	Missing No. (%)
Age			
≤ 45 Years	19	67.9	-
> 45 Years	9	32.1	
Gender			
Male	7	25.0	-
Female	21	75.0	
Completed one year of internship after graduation			
	28	100.0	-
Received postgraduate training after internship			
Yes	27	96.4	-
No	1	3.6	
Training Duration			
≤ 3 Year	6	26.1	5 (17.9)
> 3 Year	17	73.9	
Training Country			
Bahrain	15	75.0	-
Outside Bahrain	5	25.0	
Training type			
Master Degree	6	24.0	3 (10.7)
Fellowship	6	24.0	
Arab Board & Irish Board	10	40.0	
Others	3	12.0	
Attending any CME programs			
Yes	27	100.0	1 (3.6)
If "yes", Number of CME Credit hours attended in a year			
≤ 20	6	22.2	1 (3.6)
> 20	21	77.8	
The average number of patient seen daily per working shift			
< 25	2	7.4	-
≤ 25	25	92.6	
The average time spent with a patient during consultation			
5 Minutes	7	25.0	-
> 5 Minutes	21	75.0	

Type of health facilities:
Twenty-seven FPs (96.4%) are working in Primary Health Care Center and one in a private sector. Almost all the health facilities except one were governmental organizations.

Work atmosphere at the health facilities:
Only seventeen physicians (63%) believed that the PHC that they work-in, promote the culture of PCC practice and 55.6% indicated that their health organization/facility provided training on PCC. However, 17 (63%) stated that there are no any promotional incentives for using and applying PCC in their PHC and 15 (55.6%) thought that the physical and organizational environment for PCC in their facility are not available. Sixteen (59.3%) and 18 (66.7%) believed that within their health facilities no any means/tool available for evaluation of PCC and there is no any existing mechanism for performance evaluation of PCC implementation. Twenty (74.1%) believed that there is no self-assessment inventory for PCC application in their facilities, and when asked what they thought about the overall patients' impression on the use of PCC in their facilities, only 14(56%) physicians believed that it was excellent or and very good.(Table 2)

Table 2: The Health Facilities

		Yes no. (%)	No no. (%)	Don't Know no. (%)	Missing no. (%)
1	Does the facility promote the culture of PCC practice?	17 (63.0)	9 (33.3)	1 (3.7)	1 (3.6)
2	Is the use of PCC a priority in your facility?	11 (40.7)	13 (48.1)	3 (11.1)	1 (3.6)
3	Is the work physical and organizational environment in facility available for PCC?	12 (44.4)	15 (55.6)	0	1 (3.6)
4	Are there any promotional incentives for using and applying PCC in your facility?	6 (22.2)	17 (63.0)	4 (14.8)	1 (3.6)
5	Do your organization / facility have guidelines for implementation of PCC?	7 (25.9)	14 (51.9)	6 (22.2)	1 (3.6)
6	Do your organization / facility provide training on PCC?	15 (55.6)	8 (29.6)	4 (14.8)	1 (3.6)
7	Does the facility assist you in obtaining the required resources for PCC?	8 (29.6)	12 (44.4)	7 (25.9)	1 (3.6)
8	Is there any mean/tool for evaluation of PCC in your facility?	5 (18.5)	16 (59.3)	6 (22.2)	1 (3.6)
9	Do you have any existing mechanism for performance evaluation of PCC implementation in your facility?	7 (25.9)	18 (66.7)	2 (7.4)	1 (3.6)
10	Is there a self-assessment inventory for PCC implementation in your facility?	4 (14.8)	20 (74.1)	3 (11.1)	1 (3.6)
11	What do you think the overall impression of the patients on the use of PCC?	Excellent 4 (16.0)	Very good 10 (40.0)	Good 11 (44.0)	3 (10.7)

Obstacles against implementing PCC:

Initially, the participants were asked whether they agree or disagree with the following presented definition for PCC (*it is the medical care given to a person considering him/her as a person whose health need to be maintained, and promoted and the disease be prevented).* The majority, 23 (85.2%) out of the 27 respondents, agreed and thought that it is the proper definition, while one disagreed and three did not know. Twenty-three FPs (82.1%) preferred PCC to doctor-centered care because it has better impact on the outcome of the consultation process and it would improve patients' satisfaction. However, 21 (91.3%) thought that in addition, it would improve the doctors' satisfaction.

When asked to whether they agree or disagree to a pre-structured list of obstacles against full implementation of PCC, almost all FPs (96.4%) thought that the most common barrier for not implementing PCC approach is "*the time constrains*" and "*increased time required for the consultation*" (92.9%). This is followed by *"patient's desire to allow the doctors decide for them*" (64.3%), "*cultural reas*ons" (44.4%) and "*involvement of patient's family in the treatment decisions"* (35.7%). Only 4 (14.3%) believed that "*religious reasons*" could be a barrier against PCC. Since there are a quite large number of expatriate living in Bahrain and many visit PHC centers to consult doctors, it was found that 57.1%, and 53.6% of the FPs thought that the language and the doctor's communication skills are other barriers, respectively.(Table 3)

Table 3: Obstacles against implementing PCC

No	Obstacles	Yes no. (%)	No no. (%)	Don't Know no. (%)
1	Time constraint during Consultation	27 (96.4)	1 (3.6)	0
2	Increased cost of Consultation	4 (14.3)	17 (60.7)	7 (25.0)
3	Length or duration of the Consultation	26 (92.9)	1 (3.6)	1 (3.6)
4	Communication skills of Doctors	15 (53.6)	13 (46.4)	0
5	Doctors are considered superior who should make decision for patients	1 (3.6)	25 (89.3)	2 (7.1)
6	Doctor's desire to control Patient choices	5 (17.9)	20 (71.4)	3 (10.7)
7	Patient's desire to allow the Doctors decide for them	18 (64.3)	8 (28.6)	2 (7.1)
8	Involvement of Patient family in treatment decisions	10 (35.7)	15 (53.6)	3 (10.7)
9	Language Barriers	16 (57.1)	12 (42.9)	0
10	Religious reasons	4 (14.3)	23 (82.1)	1 (3.6)
11	Cultural reasons	12 (44.4)	13 (48.1)	2 (7.4)

FPs' view about measures to be taken for improving PCC approach:

Out of the majority, 22(78.6%) FPs who thought that time constraint is associated with PCC consultation stated that the following measures could manage such problem; by "improving physician efficiency during patient-physician consultation" (100%), "improving patient efficiency by educating them in the use of this model" 21(95.5%) and 21(95.5%) said by "reducing number of patients seen by a physician in any clinic slot".

Sixteen (61.5%) FPs think that the increased cost associated with PCC consultation could be reduced by "improving physician efficiency during patient-physician consultation" and "by improving patient efficiency through educating them about the proper method of using this model." However, 20 (74.1%) thought that there are measures that could be implemented to overcome the cultural beliefs and practices to support the practices of PCC, and 16 (64.0%) agreed that lobbying with policy makers will help promote PCC.(Table 4)

Using Fisher exact test to measure the association between obstacles against implementing PCC and the health facilities with participants' characteristics revealed that there is only a significant association between the training 97

Table 4: Doctors' view about measures of improving PCC approach

		Yes no. (%)	No no. (%)	Don't Know	Missing no. (%)
1	**Could the time constraint associated with PPC be managed?**	22 (78.6)	3 (10..7)	3 (10.7)	-
	If "Yes" then how:				
	-Improving Physician efficiency during Consultation	22 (100)	0	0	-
	-Improving Patient efficiency by educating them in use of this model	21 (95.5)	0	1 (4.5)	-
	-Reducing number of Patients seen by a Physician in a clinic slot	21 (95.5)	0	1 4.5)	-
2	**Could the increased cost associated with PPC be reduced?**	16 (61.5)	3 (11.5)	7 (26.9)	2 (7.1)
	If "Yes" then how:				
	- Improving Physician efficiency during the Consultation	15 (100)	0	0	1 (6.25)
	-Improving Patient efficiency by educating them in use of this model	15 (93.8)	0	1 (6.3)	-
	- Accept increase in cost in interest of better consultation outcome	12 (80.0)	3 (20.0)	0	1 (6.25)
3	**Can Patients be educated to overcome their belief that Doctors can make better decisions for their treatment?**	25 (92.6)	1 (3.7)	1 (3.7)	1 (3.6)
4	**Could the Doctors be trained and educated to accept and practice PPC?**	27 (100)	0	0	1 (3.6)
5	**Is there a need to educate the general public through media about PCC?**	26 (96.3)	1 (3.7)	0	1 (3.6)
6	**Is it true that Patients feel Doctor is incompetent when he asks Patient to make informed decisions about their treatment?**	3 (11.5)	20 (76.9)	3 (11.5)	2 (7.1)
7	**Can we overcome cultural beliefs and practices to support practice of PCC?**	20 (74.1)	0	7 (25.9)	1 (3.6)
	If "Yes" then select from the following:				
	- Patient education about Person Centered care	20 (100)	0	0	-
	- Physician education about Person Centered care	20 (100)	0	0	-
	- Taking support from Community leaders after convincing them about benefits of Person Centered care Patient Physician consultation	19 (100)	0	0	1 (5.0)
8	**Do you agree that lobbying with policy makers will help promote PCC?**	16 (64.0)	1 (4.0)	8 (32.0)	3 (10.7)

DISCUSSION

When patient seeks help from a physician, he/she should not be considered a disease or an illness but mainly a human being who is suffering from a problem. In addition, he/she cannot be separated from the management decision. It is imperative that the concept of personalized care that is tailor-made for each individual separately is taken into consideration. For such reasons and for improving health care delivery, the Institute of Medicine (IOM) in the USA suggested changes be made at all levels of health system, including doctor-patient relationships and named PCC as one of the six fundamental aims of the U.S. health care system[7].

Although, many physicians belief that PCC is the ideal method of patient-care ought to be provided within any medical practice in particular the primary health care sectors. Moreover, many studies reported the superiority and advantages of such model of care, the real implementation of PCC has not been very effective. It is due to many

reasons of which the most important is the lack of proper definition and the appropriate measures for assessing its outcome[8]. In limiting that confusion, the IOM defined PCC as: *"the health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs and preferences, and that patients have the education and support they need to make decisions and participate in their care"*[7]. While McCormack divided PCC into five core components; (a) consideration of the patient's beliefs and values, (b) Engagement, (c) shared decision making, (d) a sympathetic presence, and (f) provision of holistic care[9].

PCC has been reported to be a good indicator of quality of healthcare delivery in any country[10,11]. It improves the healthcare outcome through better patient's understanding of his/her own problem and sharing in the decision process while management. Ultimately, it helps in decreasing the use of diagnostic procedures, medication abuse and referral to the hospital therefore lowering the cost of the healthcare services[12]. On the other hand, physicians who are not applying PCC usually depend on other tools to reach to their diagnosis. They would order more expensive investigation tests or often refer patients to the secondary or tertiary care for diagnosis[5]. PCC also helps in increasing the public's awareness about disease and illness prevention with patient satisfaction[13,14]. Moreover, there will be improvements in certain indicators of the physical and psychological health status[15] with better outcomes in chronic illnesses[16,17,18], since PCC can engage people in living well with such chronic conditions[19]. With the PCC approach an environment is developed for a stronger and healthier doctor-patient relationships [5] while empowering patients to become active participants[20].

We found that the majority of physicians who were included in the study were well acquainted with the proper meaning of PCC, and almost all were strong believer its implementing in the practice. However, many indicated that there are many barriers to the full-scale implementation of such concept. Of which the most important is the time constraints. The average duration of consultation in the PHC centers in this part of the world is seven minutes that looks to be not at all enough for PCC. Similar finding was reported by others who thought that reduction in the time spent with individual patients would degrade the patient's experience and decrease the relationships and care given by physicians to their patients[2,22]. Wagner et al., 1996 advised to reorganize the practice in order to provide more time for patients who requires that so that PCC approach could be implemented effectively[21]. 64% of the physicians thought that another obstacles against PCC is the Patient's desire to allow doctors to decide for them which is the paternalism approach, a finding that has been supported by other invesitgators[22]. Almost all of the studied physicians thought that PCC implementation needs more wisdom, skills, training and knowledge. Similar finding was reported by others[22,23].

Since the ultimate aim of provision of health care in any country is the optimal health of the total population and since PCC practice could support and help in achieving that goal, it is recommended that policy-makers and health authorities work on removing all obstacles to implementing PCC and change the work environment in order to make it easy for the practitioners to apply PCC practice.

CONCLUSION

Family physicians prefer to have the PCC approach incorporated within the health care services because they believe that it has many benefits for both the patients and the health care providers than the traditional model of consultations. However, many obstacles could intervene with the full implementation of the PCC method. Of which the most important is the short time allotted for each consultation. However, more time means more man power which makes the solution a political rather than medical. It is recommended that policy-makers should provide all the facilities for the provision of PCC which will reflect on the health of the whole community. On the other hand, physicians and allied health workers must cooperate and work together for the better provision of PCC as Kiston et al., indicated that the effect of PCC is larger when the approach is comprehensively applied within all the routine health services[24].

Ethical consideration

Approval for conducting the study was obtained from various related bodies. Verbal consent was taken from all the participants who were ensured about the confidentiality of the collected information and their identity will be obscured.

Conflict of interest:
The authors admit that they have no commercial association or other that might pose a conflict of interest either directly or through immediate family.

Authors' Contribution:
Authors; Faisal A Alnasir (FA), Ahmed Jaradat (AJ)

Both FA and AJ put the study concepts.

FA carried out the literature review, re-designed the questionnaire, implemented the methodological part of the study, discussed the results and wrote the whole article.

AJ helped in the statistical analysis and interpretation of the results. Wrote the analysis and revised the whole article.

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REFERENCES

[1] Shaller D. Patient-centered care: what does it take? Picker Institute, Oxford and the Commonwealth Fund.2007.http://www.tinyurl.com/shaller
[2] Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. Ann Fam Med. 2005;2:159-66.
[3] Stewart M. Towards a global definition of patient centred care. BMJ.2001; 322:7284: 444-5.
[4] Ponte PR, Conlin G, Conway JB, Grant S, Medeiros C, Nies J, Shulman L, Branowicki P, Conley K. Making patient-centered care come alive: achieving full integration of the patient's perspective. J Nurs Adm. 2003; 33:2: 82-90.
[5] James Rickert. Patient-Centered Care: What it means and how to get there. Health Affairs Blog. Jan 2012. http://www.healthaffairs.org/blog/2012/01/24/
[6] Waris Qidwai, Kashmira Nanji,Tawfik A M Khoja, Salman Rawaf, Nabil Yasin AlKurashi, Faisal Alnasir, Mohammed Ali AlShafaee, Mariam AlShetti, Muntazar Bashir, Nagwa Eid Sobhy Saad, Sanaa Alkaisi, Wafa Halasa, Huda Al-Duwaisan, Amal Al-Ali. "Barriers, Challenges and Way Forward for Implementation of Person Centered Care Model of Patient and Physician Consultation: A Survey of Patients' Perspective from Eastern Mediterranean Countries. Middle East Journal of Family Medicine 2015;13: 3: 4-11.
[7] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century, Vol. 6Washington, DC: National Academy Press; 2001.
[8] Robinson JH, Callister LC, Berry JA, Dearing KA. Patient-centered care and adherence: definitions and applications to improve outcomes. J Am Acad Nurse Pract. 2008;20:12:600-7.
[9] McCormack, Brendan and McCance, Tanya (2010). Person-Centered Nursing; Theory, Models and Methods. Wiley-Blackwell.2008. pp ISBN 978-1405171137.
[10] deLabrusse C, Ramelet AS, Humphrey T, Maclennan SJ. Patient-centered Care in Maternity Services: A Critical Appraisal and Synthesis of the Literature. Womens Health Issues. 2016;26:1:100-9.
[11] Hanyok, Laura A. Hellmann, David B; Rand, Cynthia; Ziegelstein, Roy C. Practicing Patient-Centered Care. The Patient. 2012;5:3:141-5.
[12] BertakisKlea D, Azari Rahman. Patient-centered care is associated with decreased healthcare utilization. Journal of the American Board of Family Medicine.2011; 24: 3: 229-39
[13] Stewart M, Brown J, Weston W, McWhinney C, Freeman T. Patient- Centered Medicine. Transforming the Clinical Method. Sage Publication. International Educational and Professional Publisher; 1995.
[14] Stewart M. Brown J B. Donner A. The impact of patient-centered care on outcomes. The Journal of family practice. 2000; 49: 9: 796-804.
[15] Otero C(1), Luna D, Marcelo A, Househ M, Mandirola H, Curioso W, Pazos P, Villalba C. Why Patient Centered Care Coordination Is Important in Developing Countries? Contribution of the IMIA Health Informatics for Development Working Group. Yearb Med Inform. 2015;13:10:1:30-3.
[16] Brown, Sharon A. Studies of Educational Interventions and Outcomes in Diabetic Adults: A Meta-Analysis Revisited. Patient Education and Counselling. 1990;16:189-215.

[17] DeBusk, Robert F., Nancy Houston Miller, H. Robert Superko, et al. A Case-Management System for Coronary Risk factor Modification after Acute Myocardial Infarction. Ann Int Med. 1994;120:721-9.
[18] Mullen PD, Laville EA, Biddle AK, LorigK. Efficacy of psycho-educational interventions on pain, depression, and disability in people with arthritis: a meta-analysis. J Rheumatol Suppl. 1987;14:15:33-9.
[19] Zoffmann V, Hörnsten Å, Storbækken S, Graue M, Rasmussen B, Wahl A, Kirkevold M. Translating person-centered care into practice: A comparative analysis of motivational interviewing, illness-integration support, and guided self-determination. Patient Educ Couns. 2015; 30:.pii: S0738-3991(15)30096-3.
[20] Reynolds April. Patient-centered Care. Radiologic Technology. 2009;81:2:133-47.
[21] Wagner Edward H., Brian T Austin, Michael Von Korff. Organizing Care for Patients with Chronic Illness. Milbank Quarterly. 1996;74:4:511-42.
[22] Nick Dunn, Practical issues around putting the patient at the centre of care. J R Soc Med. 2003; 96:7: 325–7.
[23] Pelzang R. Time to learn: understanding patient-centred care. Br J Nurs. 2010;11:19:14:912-7.
[24] Kitson A, Marshall A, Bassett K, Zeitz K. What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. J Adv Nurs. 2013;69:1:4–15.